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Attorneys for Defendant
Elliot Brandwene, M.D. and Stewart Lauterbach, M.D.

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CYNTHIA GUTIERREZ, JOSE HUERTA, SMH, RH and AH, Plaintiffs, vs. SANTA ROSA MEMORIAL HOSPITAL, ST. JOSEPH HEALTH and DOES 1-50, inclusive, Defendants.	Case No. 16-CV-02645-SI **EVIDENCE IN SUPPORT OF MOTION OF DEFENDANT STEWART LAUTERBACH, M.D. FOR SUMMARY JUDGMENT** **Date: June 8, 2018** **Time: 9:00 AM** **Dept.: Courtroom 1 – 17th Floor** **Complaint Filed:** May 17, 2016 **Trial:** November 19, 2018 ASSIGNED FOR ALL PURPOSES TO: **HON. SUSAN ILLSTON**

Comes now Defendant Stewart Lauterbach, M.D. and submits the following evidence in support of his motion for summary judgment.

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Exhibit F Declaration of Alexander M. Aronov in Support of Stewart Lauterbach, M.D.'s Motion for Summary Judgment.

Dated: 04/25/2018

DONNELLY NELSON DEPOLO MURRAY & EFREMSKY

By: Alex Aronov
ALEXANDER M. ARONOV
Attorneys For Defendant
Elliot Brandwene, M.D. and Stewart Lauterbach, M.D.

EXHIBIT A

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Attorneys for Plaintiffs

UNITED STATE DISTRICT COURT

Northern District of California

CYNTHIA GUTIERREZ, JOSE HUERTA, SMH, RH and AH,

Plaintiffs,

vs.

SANTA ROSA MEMORIAL HOSPITAL, ST. JOSEPH HEALTH and DOES 1-50, inclusive,

Defendants.
_____/

Case No.

COMPLAINT

STATEMENT OF THE CASE

1. CYNTHIA GUTIERREZ was 33 years old when she presented to Defendant SANTA ROSA MEMORIAL HOSPITAL at approximately 3:00 a.m. on February 25, 2015.

2. CYNTHIA GUTIERREZ was diabetic. She had end stage renal disease. She weighed 134 pounds and was 5' 2" tall.

3. She worked at a Panera restaurant in Rohnert Park, California.

4. Her husband is JOSE HUERTA. They have three minor children, ages 15, 11 and 8.

5. Because of her medical conditions, CYNTHIA was frequently a patient at SANTA ROSA MEMORIAL HOSPITAL'S emergency room.

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6. On this particular occasion, various laboratory and diagnostic tests were ordered. Many of the test results were remarkable for the presence of life threatening disease.

7. Inexplicably, these "red flags" were ignored.

8. CYNTHIA was discharged from the emergency room at approximately 7:00 a.m.

9. CYNTHIA was sitting in the waiting room when she collapsed.

10. A Code Blue was called and she was resuscitated.

11. She was transferred to the ICU.

12. She has remained in a coma.

13. No explanation has been provided to the family as to how this occurred.

14. CYNTHIA has remained at SANTA ROSA MEMORIAL HOSPITAL, despite attempts to transfer her elsewhere.

IDENTIFICATION OF PARTIES

A. Plaintiffs.

15. CYNTHIA GUTIERREZ, 200 Craubrook Way #203, Santa Rosa, CA 95407.

16. JOSE HUERTA, 200 Craubrook Way #203, Santa Rosa, CA 95407.

17. SMH, 200 Craubrook Way #203, Santa Rosa, CA 95407.

18. RH, 200 Craubrook Way #203, Santa Rosa, CA 95407.

19. AH, 200 Craubrook Way #203, Santa Rosa, CA 95407.

B. Defendants.

20. SANTA ROSA MEMORIAL HOSPITAL (SRMH), 1165 Montgomery Drive, Santa Rosa, California 95405.

21. ST. JOSEPH HEALTH, 3345 Michelson Drive, Ste 100, Irvine, CA 92612.

22. Does 1-50.

JURISDICTION AND VENUE

23. This case belongs in federal court under federal question jurisdiction because it is about federal law(s) or right(s) of EMTALA.

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24. Venue is appropriate in this Court because all Defendants live in California and at least one of the Defendants lives in this district and because a substantial part of the events being sued about happened in this district.

25. Plaintiffs hereby demand a jury trial in this action.

INTRADISTRICT ASSIGNMENT

26. This lawsuit should be assigned to San Francisco/Oakland Division of this Court because this is the district where the event occurred.

STATEMENT OF FACTS AND CLAIMS

27. CYNTHIA GUTIERREZ was 33 years old when she presented to Defendant SRMH at approximately 3:00 a.m. on February 25, 2015.

28. CYNTHIA GUTIERREZ was diabetic. She had end stage renal disease. She weighed 134 pounds and was 5' 2" tall.

29. She worked at a Panera restaurant in Rohnert Park, California.

30. Her husband is JOSE HUERTA.

31. Because of her medical conditions, CYNTHIA was frequently a patient at SRMH'S emergency room.

32. On this particular occasion, various laboratory and diagnostic tests were ordered. Many of the test results were remarkable for the presence of life threatening disease.

33. Inexplicably, these "red flags" were ignored.

34. CYNTHIA was discharged from the emergency room at approximately 7:00 a.m.

35. CYNTHIA was sitting in the waiting room when she collapsed.

36. A Code Blue was called and she was resuscitated.

37. She was transferred to the ICU.

38. She has remained in a coma.

39. No explanation has been provided to the family as to how this occurred.

40. CYNTHIA has remained at SRMH, despite attempts to transfer her elsewhere.

41. Defendants performed a cursory and inadequate screening.

42. Defendants failed to stabilize CYNTHIA GUTIERREZ.

43. Defendants ignored even their own test results showing life-threatening, unstable conditions. They nonetheless intentionally and recklessly chose to simply discharge CYNTHIA GUTIERREZ.

44. As such, Defendants failed to comply with EMTALA requirements to reasonably screen and stabilize.

45. Defendants intentionally and recklessly and negligently refused and failed to follow federal law EMTALA and state law and their own policies and procedures all of which mandated medical screening and stabilization CYNTHIA'S emergency medical conditions when she presented to their ER.

46. Defendants' pattern and practice was to deny and avoid care for indigent and uninsured and underinsured and those with substance and/or mental health issues or apparent questionable immigration status.

47. Despite claiming to be a charitable and caring organization by history Defendants have instead placed corporate profits and revenues ahead of patient care and safety due to financial pressures they have received from competing facilities including but not limited to Sutter Heath and Kaiser and for other unknown reasons.

48. Defendants have previously and repeatedly "dumped" other patients in violation of EMTALA including but not limited to Michael Torres, whom they discharged to die in their parking lot due to severe pneumonia of days duration which went undiagnosed and untreated and for which the hospital was cited by federal authorities. They also "dumped" and refused even the most cursory exam to another recent victim who wishes to not be identified in the Complaint. They were also cited by Federal authorities for this second previous case.

49. Both such cases were prosecuted by the undersigned.

50. Defendants have also effectively discharged other patients by making them wait inordinate times and discouraging them from coming to the ER and by pretending to perform the requisite screening and stabilization procedures but instead minimizing all contacts and care and

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only seeking to try to avoid liability for violating EMTALA and other laws and the hospital's own policies and procedures.

51. SRMH has been repeatedly been cited for intentional understaffing by the CDPH [California Department of Public Health.]

52. SRMH has repeatedly discharged patients prematurely in order to maximize their income and profits regardless of the risks imposed thereby on the patients.

FIRST CAUSE OF ACTION

(EMTALA 42 U.S.C. 1395dd)

53. Plaintiffs reincorporate paragraphs 1 through 53, above.

54. Defendants dumped and failed to screen or stabilize CYNTHIA GUTIERREZ in violation of this law.

SECOND CAUSE OF ACTION

(WELFARE & INSTITUTIONS CODE 15657 including 15657 Enhanced Remedies)

55. Plaintiffs reincorporate paragraphs 1 through 54 above.

56. CYNTHIA GUTIERREZ was a dependent adult per Welfare and Institutions Section 15600, et seq. Defendants intentionally and recklessly neglected CYNTHIA causing her severe suffering and emotional distress.

THIRD CAUSE OF ACTION

(Negligence)

57. Plaintiffs reincorporate paragraphs 1 through 56 above.

58. General negligence including unreasonable care in violation of the above stated Federal and California statutory law and as well as in violation of Defendants' own policies and procedures as well as breach of Defendants' general and fiduciary duties to provide standard and reasonable care. Plaintiffs and each of them also claim damages as direct victims and as bystanders due to negligent infliction of emotional distress.

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DEMAND FOR RELIEF

Wherefore, Plaintiffs pray for relief as follows:

1. For damages, economic and non-economic, to each of Plaintiff according to proof;

2. For enhanced remedies pursuant to California State Welfare & Institutions Code §15657 including attorney fees;

3. For exemplary/punitive damages including but not limited to as provided for by California Civil Code §3294 based on Welfare & Institutions Code §15600, et seq. and EMTALA;

4. For EMTALA related remedies including, but not limited to, attorney fees and costs and compensation to CYNTHIA GUTIERREZ and JOSE HUERTA and their family members and loved ones; and

5. Prejudgement interest in the amount of 10% per year or at the maximum level recoverable by law.

DATED: May 16, 2016

LAW OFFICES OF DOUGLAS C. FLADSETH

/s/

DOUGLAS C. FLADSETH
Attorney for Plaintiffs

DEMAND FOR JURY TRIAL

Plaintiffs hereby demand a jury trial in this action.

Dated: May 16, 2016

LAW OFFICES OF DOUGLAS C. FLADSETH

/s/

DOUGLAS C. FLADSETH
Attorney for Plaintiffs

EXHIBIT B

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Attorneys for Plaintiffs

UNITED STATE DISTRICT COURT

Northern District of California

CYNTHIA GUTIERREZ, JOSE HUERTA, SMH, RH and AH,

Plaintiffs,

vs.

SANTA ROSA MEMORIAL HOSPITAL, ST. JOSEPH HEALTH, TEAMHEALTH, CHASE DENNIS EMERGENCY MEDICAL GROUP, INC. ELLIOT BRANDWENE, M.D., STEWART LAUTERBACH, M.D. and DOES 1-50, inclusive,

Defendants.
_____/

Case No. 16-cv-02645-SI

SECOND AMENDED COMPLAINT

STATEMENT OF THE CASE

1. CYNTHIA GUTIERREZ was 33 years old when she presented to Defendant SANTA ROSA MEMORIAL HOSPITAL at approximately 3:00 a.m. on February 25, 2015.

2. CYNTHIA GUTIERREZ was diabetic. She had end stage renal disease. She weighed 134 pounds and was 5' 2" tall.

3. She worked at a Panera restaurant in Rohnert Park, California.

4. Her husband is JOSE HUERTA. They have three minor children, ages 15, 11 and 8.

///

5. Because of her medical conditions, CYNTHIA was frequently a patient at SANTA ROSA MEMORIAL HOSPITAL'S emergency room.

6. CYNTHIA had a previously documented severe adverse reaction/allergy to Dilaudid,

7. On this particular occasion, various laboratory and diagnostic tests were ordered. Many of the test results were remarkable for the presence of life threatening disease.

8. Inexplicably, these "red flags" were ignored.

9. CYNTHIA was discharged from the emergency room at approximately 6:35 a.m.

10. CYNTHIA was sitting in the waiting room when she collapsed.

11. CYNTHIA was administered Dilaudid shortly before her collapse.

12. A Code Blue was called and she was resuscitated.

13. She was transferred to the ICU.

14. She has remained in a coma.

15. No explanation has been provided to the family as to how this occurred.

16. CYNTHIA remained at SANTA ROSA MEMORIAL HOSPITAL for many months and is currently at Kentfield Rehabilitation Center.

IDENTIFICATION OF PARTIES

A. Plaintiffs.

17. CYNTHIA GUTIERREZ, 200 Craubrook Way #203, Santa Rosa, CA 95407.

18. JOSE HUERTA, 200 Craubrook Way #203, Santa Rosa, CA 95407.

19. SMH, 200 Craubrook Way #203, Santa Rosa, CA 95407.

20. RH, 200 Craubrook Way #203, Santa Rosa, CA 95407.

21. AH, 200 Craubrook Way #203, Santa Rosa, CA 95407.

B. Defendants.

22. SANTA ROSA MEMORIAL HOSPITAL (SRMH), 1165 Montgomery Drive, Santa Rosa, California 95405.

23. ST. JOSEPH HEALTH, 3345 Michelson Drive, Ste 100, Irvine, CA 92612.

24. TEAMHEALTH, 265 Brookview Centre Way, Ste 400, Knoxville, TN 37919

25. CHASE DENNIS EMERGENCY MEDICAL GROUP, INC., 1165 Montgomery Drive, Santa Rosa, California 95405.

26. ELLIOT BRANDWENE, M.D., 3105 Burkhart Ln, Sebastopol, CA 95472

27. STEWART LAUTERBACH, M.D., 1165 Montgomery Drive, Santa Rosa, CA 95405

JURISDICTION AND VENUE

28. This case belongs in federal court under federal question jurisdiction because it is about federal law(s) or right(s) of EMTALA.

29. Venue is appropriate in this Court because the majority of the Defendants are based in California and at least one of the Defendants lives in this district and because a substantial part of the events being sued about happened in this district.

30. Plaintiffs hereby demand a jury trial in this action.

INTRADISTRICT ASSIGNMENT

31. This lawsuit should be assigned to San Francisco/Oakland Division of this Court because this is the district where the event occurred.

STATEMENT OF FACTS AND CLAIMS

32. CYNTHIA GUTIERREZ was 33 years old when she presented to Defendant SRMH at approximately 3:00 a.m. on February 25, 2015. She presented with persistent shortness of breath since 7:00pm the evening before.

33. CYNTHIA GUTIERREZ was diabetic. She had end stage renal disease. She weighed 134 pounds and was 5' 2" tall.

34. CYNTHIA GUTIERREZ had, in defendant hospital's records, previously documented severe adverse reaction(s) to Dilaudid.

35. CYNTHIA GUTIERREZ previously worked at a Panera restaurant in Rohnert Park, California.

36. CYNTHIA GUTIERREZ's husband is JOSE HUERTA. She has three minor children.

///

37. Because of her medical conditions, CYNTHIA was frequently a patient at SRMH'S emergency room.

38. On this particular occasion, various laboratory and diagnostic tests were ordered. Many of the test results were remarkable for the presence of life threatening disease. Supplemental oxygen was started. Her blood pressure was recorded as 177/97 at 3:51 a.m. At 5:27 a.m. her blood glucose was recorded as 418 which is extremely out of normal range. Her Brain Natriuretic Peptide (BNP) was > 5000 with the normal range being 0-100. This evidences profound congestive heart failure. A chest x-ray demonstrated prominence of the pulmonary vascularity as well as bilateral interstitial infiltrates evidencing fluid overload with congestive heart failure.

39. Despite this clear evidence of life threatening disease in a known diabetic with grossly abnormal blood sugar and extreme evidence of heart failure absolutely no screening was done to determine the presence or absence of diabetic ketoacidosis. The laboratory tests necessary to screen for this apparent disease process were simply not done. These necessary screening tests none of which were done include: 1. arterial blood gas, 2. urinalysis, 3. serum ketones and 4. anion gap calculations. These are all routine and standard screening exams especially for patients who present with compelling evidence of acute diabetic ketoacidosis.

40. Instead of admitting CYNTHIA and providing the necessary screening tests and care, defendants chose instead to simply overdose her on narcotic pain medications which would further suppress her respiratory system and discharge her from the hospital. At 4:21 a.m. she was given 1 mg IV of Dilaudid. At 6:22 a.m. she was given an additional 1mg IV of Dilaudid. The Dilaudid was given ostensibly for right hand pain from peripheral neuropathy. It is not a usual or appropriate narcotic for that purpose. Dilaudid is synthetic heroin, eight times stronger than morphine. It is a respiratory depressant being given to a patient who presented with respiratory difficulty. It is contraindicated for someone like CYNTHIA who presents with respiratory distress such as persistent shortness of breath and particularly for someone with compelling evidence of acute congestive heart failure and fluid overload.

///

41. Simply masking the problem and discharging the patient abdicates the ER's responsibility to provide appropriate screening tests as part of basic and fundamental emergency care.

42. CYNTHIA was discharged from the emergency room at 7:00 a.m. The ER physician and staff failed to admit MS. GUITIERREZ who continued to need ongoing screening, monitoring, care, treatment and custody for her acute condition.

43. CYNTHIA was sitting in the ER waiting room when she collapsed.

44. CYNTHIA was administered Dilaudid shortly before her collapse.

45. At 7:26 a.m. a Code Blue was called. This was one hour and four minutes after the staff administered IV Dilaudid to MS. GUTIERREZ. The record indicates she had no respirations at this time. Resuscitation was initiated.

46. She was transferred to the ICU.

47. She has remained in a coma.

48. No explanation has been provided to the family as to how this occurred.

49. Defendants performed a cursory and inadequate screening.

50. Defendants failed to stabilize CYNTHIA GUTIERREZ.

51. Defendants ignored even their own test results showing life-threatening, unstable conditions. They nonetheless intentionally and recklessly chose to simply discharge CYNTHIA GUTIERREZ.

52. As such, Defendants failed to comply with EMTALA requirements to reasonably screen and stabilize.

53. Defendants intentionally and recklessly and negligently refused and failed to follow federal law EMTALA and state law and their own policies and procedures all of which mandated medical screening and stabilization of CYNTHIA'S emergency medical conditions when she presented to their ER.

54. Defendants' pattern and practice was to deny and avoid care for indigent and uninsured and under insured and including, but not limited to, Medi-Cal patients such as CYNTHIA and those with substance and/or mental health issues and/or apparent minority or

questionable immigration status and/or with Hispanic surnames and/or appearances such as CYNTHIA GUTIERREZ.

55. Despite claiming to be a charitable and caring organization by history Defendants have instead placed corporate profits and revenues ahead of patient care and safety due to financial pressures they have received from competing facilities including but not limited to Sutter Heath and Kaiser and for other unknown reasons.

56. Two prior cases, violating EMTALA by these same defendants, have also been prosecuted by the undersigned. It is requested that the court take judicial notice of the federal and state investigations copies attached hereto as Exhibit 1 & 2 citing these same defendants for EMTALA and other violations in each of the above mentioned cases.

57. Defendants have also effectively discharged other patients by making them wait inordinate times and discouraging them from coming to the ER and by pretending to perform the requisite screening and stabilization procedures but instead minimizing all contacts and care and only seeking to try to avoid liability for violating EMTALA and other laws and the hospital's own policies and procedures.

58. SRMH has been repeatedly been cited for intentional understaffing by the CDPH [California Department of Public Health.]

59. It has just been discovered, at the deposition of CPR responding Emergency room doctor, Dr. Lauterbach, taken by the hospital's attorney, beginning on March 22, 2017, that defendants have unreasonably failed to provide and include all the critical records pertaining to this event. Defendants for the first time produced a next day "addendum" authored by the CPR responding Emergency room doctor, Dr. Lauterbach, claiming that CYNTHIA GUITIERREZ was found to have food blocking her airway. No such blockage was mentioned in any of the previously provided records (>30,000 produced), including but not limited to the original note by Dr. Lauterbach, nor by the responding Respiratory Therapist, nor by the treating ICU doctor, nor anyone else, that day, nor at any other time (other than a few vague references by Defendant only after this motion was filed and without apparent basis since no "addendum" was in the originally produced records).

60. It has also just been discovered, at the deposition of CPR responding Emergency room doctor, Dr. Lauterbach, taken by the hospital's attorney, beginning on March 22, 2017, by and through the hospital attorney's questioning, that the previously documented history of major adverse reactions to Dilaudid was ignored and undocumented, thereby concealing a significantly reckless contribution to CYNTHIA GUTIERREZ respiratory arrest.

61. CYNTHIA GUTIERREZ hereby further requests leave of court for the time necessary to conduct her own discovery from defendants including but not limited to discovery of the records of other patients similarly presenting to defendant's ER and also including discovery of defendant's written policies and procedures for similarly presenting patients and also in order to obtain testimony under oath from the treating doctors and nurses at defendants ER regarding the practices and policies and procedures in place at this ER. This discovery will allow CYNTHIA to further elaborate her factual basis for disparate screening.

62. CYNTHIA GUTIERREZ hereby further requests leave of court for the time necessary to conduct her own discovery from defendants including but not limited to defendants' EMR (Electronic Medical Records) in use at the time in question and also including defendants' EMR policies and procedures and also including

FIRST CAUSE OF ACTION

(EMTALA 42 U.S.C. 1395dd)

63. Plaintiffs reincorporate paragraphs 1 through 62, above.

64. Defendants "dumped" and failed to screen or stabilize CYNTHIA GUTIERREZ in violation of this law.

SECOND CAUSE OF ACTION

(Negligence)

65. Plaintiffs reincorporate paragraphs 1 through 64 above.

66. General negligence including unreasonable care and lack of reasonable and necessary care in violation of the above stated Federal and California statutory law and as well as in violation of Defendants' own policies and procedures as well as breach of Defendants' general and fiduciary duties to provide standard and reasonable care. Plaintiffs and each of them also

claim damages as direct victims and as bystanders due to negligent infliction of emotional distress.

DEMAND FOR RELIEF

Wherefore, Plaintiffs pray for relief as follows:

1. For damages, economic and non-economic, to each of Plaintiffs according to proof;

2. For enhanced remedies EMTALA, including attorneys fees;

3. For exemplary/punitive damages including but not limited to as provided for by EMTALA;

4. For EMTALA related remedies including, but not limited to, attorney fees and costs and compensation to CYNTHIA GUTIERREZ and JOSE HUERTA and their family members and loved ones; and

5. Prejudgement interest in the amount of 10% per year or at the maximum level recoverable by law.

DATED: July 3, 2017

LAW OFFICES OF DOUGLAS C. FLADSETH

/s/

DOUGLAS C. FLADSETH
Attorney for Plaintiffs

DEMAND FOR JURY TRIAL

Plaintiffs hereby demand a jury trial in this action.

Dated: July 3, 2017

LAW OFFICES OF DOUGLAS C. FLADSETH

/s/

DOUGLAS C. FLADSETH
Attorney for Plaintiffs

EXHIBIT C

Santa Rosa Memorial Hosp.
1165 Montgomery Dr
Santa Rosa, CA 95405
707-546-3210

MRN#: SM02706496
Patient: GUTIERREZ,CYNTHIA
Report Status: Signed
Documented By: BRAEL001
Documented Date: 02/25/15 0334

Account#: SV0083448385
Report Type: EDPHYRPT
Report Mnemonic: PHY.ER
Report#: 0225-0042
Facility: NSM

Emergency Department Report

History of Present Illness

HPI

Service date
2/25/15
Time Seen by MD: 03:34
Chief complaint: shortness of breath
The patient is a thirty three year old female with history of ESRD on hemodialysis brought in by private vehicle with persistently shortness of breath since 19:00 yesterday. She states her last dialysis was yesterday, states she was instructed to not drink to much, but admits to drinking three glasses of water yesterday evening. She denies fever, chills, cough, chest pain, nausea, vomiting, or diarrheal is having bilateral arm pain.
Onset/Duration/Timing: started approximately - 19:00 yesterday, worsening
Context:
Dyspnea
Severity: moderate
Aggravated by: lying flat
Alleviated by: sitting up

Past Medical History

Coded Allergies:
No Known Allergies (Unverified , 2/25/15)
per huisband, no known allergies

Active Scripts
Hydrocodone Bit/Acetaminophen (Norco 10-325 Tablet)10 Mg/325 Mg Tab1 Tab PO Q6HR PRN (PAIN, Moderate to Severe(4-10)) #20 TAB
Prov:Brandwene,Elliott L 2/25/15
Oxycodone Hcl/Acetaminophen (Percocet 10-325 Mg Tablet)1 Each Tablet1 Tab PO Q4HR #10 TAB
Prov:Brandwene,Elliott L 2/6/15
Hydrocodone Bit/Acetaminophen (Norco 5-325 Tablet)5 Mg/325 Mg Tab1-2 Tab PO Q6H PRN (PAIN, Moderate to Severe(4-10)) #15 TAB
Prov:Allred,Kendall S 2/1/15
Metoclopramide Hcl (Reglan)10 Mg Tab10 Mg PO ACHS #120 TAB Ref 3
Prov:Altaf,Mujeeb 1/22/15
Hydrocodone Bit/Acetaminophen (Norco 5-325 Tablet)5 Mg/325 Mg Tab1 Tab PO Q6H PRN (PAIN, Mild (1-3)) #30 TAB Ref 0
Prov:Quang,Angela M 1/16/15
Amlodipine Besylate (Norvasc)5 Mg Tab5 Mg PO DAILY 30 Days
Prov:Junck,Daniel L 1/5/15
Atorvastatin Calcium (Lipitor)20 Mg Tab20 Mg PO QPM #30 TAB Ref 0
Prov:Quang,Angela M 12/17/14
Furosemide (Lasix)80 Mg Tablet80 Mg PO DAILY #30 TAB
Prov:Altaf,Mujeeb 12/3/14
Ondansetron (Zofran Odt)4 Mg Tab.rapdis4 Mg PO BID PRN (NAUSEA/VOMITING) #10 TAB

Santa Rosa Memorial Hosp.
1165 Montgomery Dr
Santa Rosa, CA 95405
707-546-3210

Prov:Muller,Ridgely O 11/2/14

Reported Medications

Hydralazine Hcl 50 Mg Tablet50 Mg PO BID #120 TAB
1/13/15
Metoprolol Tartrate 100 Mg Tablet100 Mg PO BID #60 TAB
TO TAKE AM OF SURGERY
1/13/15
Brimonidine Tartrate (Brimonidine Tartrate 0.2%)5 Ml Drops1 Drop BOTH EYES TID #5 ML
6/7/14
Timolol Maleate (Timolol Maleate Ophth Soln 0.5%)10 Ml Drops1 Drop BOTH EYES BID #10 ML
6/7/14
Latanoprost 2.5 Ml Drops1 Drop BOTH EYES QPM #2.5 ML
6/7/14

Travel History

Travel and/or hospitalization outside the US in the last 30 days?
Past medical records: reviewed
Cardiovascular history: HTN, CAD, heart failure, : - pericardial effusion, tetrology of fallot surgery
Respiratory history: tuberculosis - TESTED POSATIVE AS A CHILD. TOOK MEDS FOR 6 MONTHYS, : - CHF, no asthma, no COPD
Neurological history: seizures - pt has not have one since age two , : - diabetic neuropathy
Endocrine history: DM type 1, DM type 2 - has been hospitlized for this many times, no hypothyroidism
Renal history: renal insufficiency - Stage 3, renal failure - CRF STAGE 3 KIDNEY DISEASE, dx'd in March 2014, dialysis - AV Fisyula left upper arm, : - hx of nephrotic syndrome with anasarca
Other pertinent history: chronic pain, back pain
Surgical history: : - partial thyroidectomy, tubal ligation, pancreas (childhood), thyroid (2011), no cholecystectomy
Other past history:
partial pancreas removal
blind in left eye secondary to glaucoma
Gynecological history: no endometriosis
Family history of:
no Pertinent family history
Other family history:
reviewed, not relevant
Smoking Status: Never A Smoker
History Of Substance Abuse: Yes
Substance: Patient Denies Substance Abuse, Illicit Drugs
Other social history:
lives with husband, 3 kids and mother-in-law
worked as a dishwasher

Review of systems

Respiratory: see HPI
Comprehensive ROS: all other systems reviewed:negative

Physical Exam

Exam

Vital signs

Initial Vital Signs

Date Time	Temp	Pulse	Resp	B/P	Pulse Ox	O2 Delivery	O2 Flow Rate	FiO2
2/25/15 03:51	98.7	86	2	177/97	94	Room Air		
2/25/15 05:27							2	

Santa Rosa Memorial Hosp.
1165 Montgomery Dr
Santa Rosa, CA 95405
707-546-3210

2/25/15 08:55								40

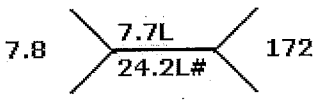
Sp O2: 94% on RA, interpretation: normal
General appearance: alert
EENT: normal eyes inspection, normal ENT inspection, normal pharynx
Respiratory: breath sounds normal, breath sounds equal
Cardiovascular: regular rate and rhythm, pulses equal/full x 4 extremities, no JVD present, no gallop, no systolic murmur, no diastolic murmur
Abdomen/GU: normal bowel sounds, soft, no distention, no tenderness, no guarding, no rebound
Skin: color normal, warm, dry, no cyanosis
Neurologic: oriented X4 and GCS = 15, cranial nerves intact, normal motor
Psych: normal mood and affect

Data
Vital Signs

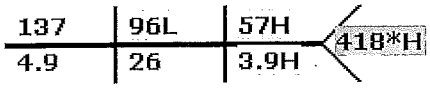
Date Time	Temp	Pulse	Resp	B/P	Pulse Ox	O2 Delivery	O2 Flow Rate	FiO2
2/25/15 08:55		86			97			40
2/25/15 07:00	98.2 98.2	83	20	145/89	97	Room Air	2	
2/25/15 06:41	98.2	83	20	145/89	97	Room Air		
2/25/15 05:27	98.2	86	21		97	Nasal Cannula	2	
2/25/15 04:27	98.7 98.7	86	2	177/97	94	Room Air		
2/25/15 03:51	98.7	86	2	177/97	94	Room Air		

Medications Administered
Given in ED

Diagnostics & Interpretation
Initial ECG (Interp. by ED MD):
Date: Feb 25, 2015
Time: 04:08
Heart rate: 86
Normals: NSR, normal axis, normal intervals
Rhythm: NSR
Interpretation: unchanged from prior, interpreted by ED MD
X-RAY (Interpreted by EP) :
Read by: Emergency Physician
X-RAY type: chest
# of views: 1
Comments
pulmonary vascular congestion
Result Diagram:
2/25/15 0350



2/25/15 0350



Lab Results

Patient: GUTIERREZ,CYNTHIA
Adm Phys:
MRN#: SM02706496

Santa Rosa Memorial Hosp.
1165 Montgomery Dr
Santa Rosa, CA 95405
707-546-3210

Laboratory Tests

Test	2/25/15 03:50	2/25/15 06:14
WBC	7.8 10^3/uL (3.5-11.0)	
RBC	2.66 L 10^6/uL (3.50-5.50)	
Hgb	7.7 L g/dL (12.0-15.0)	
Hct	24.2 #L % (36.0-45.0)	
MCV	91 # fL (79-95)	
Plt Count	172 THD/uL (120-400)	
Seg Neutrophils %	73.4 H % (34-64)	
Lymphocytes %	16.6 L % (19-48)	
Monocytes %	6.6 (3-9)	
Eosinophils %	2.4 % (0-7)	
Basophils %	1.0 % (0-2)	
Sodium	137 mmol/L (136-144)	
Potassium	4.9 mmol/L (3.6-5.1)	
Chloride	96 L mmol/L (101-111)	
Carbon Dioxide	26 mmol/L (22-32)	
Anion Gap	15.0 H (3.0-11.0)	
BUN	57 H mg/dL (8-20)	
Creatinine	3.9 H mg/dL (0.40-1.00)	
Est GFR (African Amer)	17 L ml/min (>60)	
Est GFR (Non-Af Amer)	14 L ml/min (>60)	
Glucose	418 *H mg/dL (65-99)	
Calcium	8.0 L mg/dL (8.9-10.3)	
Total Bilirubin	0.5 mg/dL (0.3-1.2)	
AST	27 IU/L (15-41)	
ALT	93 H IU/L (14-54)	
Alkaline Phosphatase	290 H IU/L (32-91)	
Rapid CK-MB (CK-2)	5.1 ng/mL	

Patient: GUTIERREZ,CYNTHIA
Adm Phys:
MRN#: SM02706496

SRMH(2) 27615

000222

Santa Rosa Memorial Hosp.
1165 Montgomery Dr
Santa Rosa, CA 95405
707-546-3210

	(0.6-6.3)	
Rapid Troponin I	< 0.05 ng/mL (<0.05)	
Rap B-Natriuretic Pept	> 5000 *H pg/mL (0-100)	
Total Protein	6.8 gm/dL (6.1-7.9)	
Albumin	3.3 L g/dL (3.5-4.8)	
Globulin	3.5 gm/dL (2.3-3.5)	
POC Glucose		313 H mg/dL (65-99)

Medical Decision Making

Progress Notes

Progress Note :
Date: Feb 25, 2015
Time: 06:05
Note
Re-examined patient, states she feels much better.

Disposition

Latest vital signs

Vital Signs

	2/25/15 07:00	2/25/15 08:55
Temp	98.2 98.2	
Pulse		86
Resp	20	
B/P	145/89	
Pulse Ox		97
O2 Delivery	Room Air	
O2 Flow Rate	2	
FiO2		40

Impression:
Primary Impression: ESRD (end stage renal disease) on dialysis
Additional Impressions: Poorly controlled diabetes mellitus, Neuropathy, Chronic pain, Anemia
Condition: Stable
Disposition: Discharge Home
Patient instructions: AFTERCARE, Diabetic Neuropathy, ED Chronic Pain, ED Chronic Renal Failure

Additional instructions:
Please follow up at dialysis as scheduled tomorrow, and return to the emergency department sooner for worsening symptoms or any other concerns.
Referrals:
Southwest Community,Health Cli (PCP)
Scripts on discharge

Patient: GUTIERREZ,CYNTHIA
Adm Phys:
MRN#: SM02706496

Santa Rosa Memorial Hosp.
1165 Montgomery Dr
Santa Rosa, CA 95405
707-546-3210

Hydrocodone Bit/Acetaminophen (Norco 10-325 Tablet)10 Mg/325 Mg Tab1 Tab PO Q6HR PRN (PAIN, Moderate to Severe(4-10)) #20 TAB
Prov:Brandwene,Elliott L 2/25/15

Attestation

Documentation prepared by Glenister, Sarah , acting as medical scribe for and in the presence of Dr. Brandwene 2/25/15 04:07

All medical record entries made by the scribe were at my direction and in my presence. I have reviewed the chart and agree that the record accurately reflects my personal performance of the history, physical exam, medical decision making, and the emergency department course for this patient. I have also personally reviewed and agree with the discharge instructions and disposition.

EMR and Dragon Attestation - this medical document was created using an electronic medical record system with Dragon computerized dictation system. Although this document has been carefully reviewed, there may still be some phonetic and typographical errors. These errors are purely typographical, due to imperfections of the software programs, and do not reflect any compromise in the patient's medical care.

Brandwene,Elliott L Feb 25, 2015 03:34
Glenister,Sarah SCRIBE Feb 25, 2015 04:07

This is not considered FINAL until Signed by a Physician

Authenticated By:
<Electronically signed by Elliott L Brandwene MD> 03/05/15 1343

Elliott L Brandwene

cc:

Patient: GUTIERREZ,CYNTHIA
Adm Phys:
MRN#: SM02706496

SRMH(2) 27617

000224

Santa Rosa Memorial

ient: GUTIERREZ,CYNTHIA 02/25/15 0341 **Room** **Acct#** SV0083448385
e/Sex 33/F **DOB** 07/31/1981 **Height** 5 ft 3 in **Unit#** SM02706496
Status DEP ER **Weight** 56.000 kg **Dep'd** 02/25/15 0702
ED.Phys Brandwene,Elliott L **PC.Phys** Southwest Community,Health Cli

PATIENT DEMOGRAPHICS

3492 STONY POINT RD
SANTA ROSA, CA 95407
714-673-1287
Insurance: Partnership Managed Medicaid
Next of Kin: HUERTA,JOSE
Relation: Husband
Phone: 714-673-1287

PCP: Southwest Community,Health Cli
Family Doctor:
Referring:

GENERAL DATA

ED Physician: Brandwene,Elliott L, ACT
Practitioner:
Nurse: Cameron,Johnnie, RN

Arrival Date/Time: 02/25/15 - 0326
Triage Date/Time: 02/25/15 - 0351
Date of Birth: 07/31/1981

Stated Complaint: CONGESTION/COUGH/NERVE PAIN?
Chief Complaint: Respiratory

Priority: 3

ALLERGIES

hydromorphone/cardiopulmonary arrest

REPORTED MEDICATIONS

Prescription/Reported Meds	Type	Issued	Provider	Entered
ONDANSETRON (ZOFRAN ODT) 4 Mg Tab.rapdis 4 MG PO Twice Daily As needed for NAUSEA/VOMITING, #10 TAB.RAPDIS	Rx	11/02/14	MULRI001	11/02/14
FUROSEMIDE (LASIX) 80 Mg Tablet 80 MG PO Daily, #30 TABLET	Rx	12/03/14	ALTMU001	12/03/14
ATORVASTATIN CALCIUM (LIPITOR) 20 Mg Tab 20 MG PO Every Evening, #30 TABLET REF 0	Rx	12/17/14	QUAAN002	12/17/14
AMLODIPINE BESYLATE (NORVASC) 5 Mg Tab 5 MG PO Daily 30 Days	Rx	01/05/15	JUNDA001	01/05/15
HYDROCODONE BIT/ACETAMINOPHEN (NORCO 5-325 TABLET) 5 Mg/325 Mg Tab 1 TAB PO Q6H As needed for PAIN, Mild (1-3), #30 TAB REF 0	Rx	01/16/15	QUAAN002	01/16/15
METOCLOPRAMIDE HCL (REGLAN) 10 Mg Tab 10 MG PO Before Meals and at Bedtime, #120 TABLET REF 3	Rx	01/22/15	ALTMU001	01/22/15
HYDROCODONE BIT/ACETAMINOPHEN (NORCO 5-325 TABLET) 5 Mg/325 Mg Tab 1-2 TAB PO Q6H As needed for PAIN, Moderate to Severe(4-10), #15 TAB	Rx	02/01/15	ALLKE002	02/01/15
OXYCODONE HCL/ACETAMINOPHEN (PERCOCET 10-325 MG TABLET) 1 Each Tablet 1 TAB PO Every 4 Hours, #10 TABLET	Rx	02/06/15	BRAEL001	02/06/15
LATANOPROST (LATANOPROST) 2.5 Ml Drops	Reported			06/07/14

Santa Rosa Memorial

Patient: GUTIERREZ,CYNTHIA 02/25/15 0341 **Room** **Acct#** SV0083448385
Age/Sex 33/F **DOB** 07/31/1981 **Height** 5 ft 3 in **Unit#** SM02706496
Status DEP ER **Weight** 56.000 kg **Dep'd** 02/25/15 0702
ED.Phys Brandwene,Elliott L **PC.Phys** Southwest Community,Health Cli

Prescription/Reported Meds	Type	Issued	Provider	Entered
1 DROP BOTH EYES Every Evening, #2.5 DROPS TIMOLOL MALEATE (TIMOLOL MALEATE OPHTH SOLN 0.5%) 10 Ml Drops	Reported			06/07/14
1 DROP BOTH EYES Twice Daily, #10 DROPS BRIMONIDINE TARTRATE (BRIMONIDINE TARTRATE 0.2%) 5 Ml Drops	Reported			06/07/14
1 DROP BOTH EYES Three Times Daily, #5 DROPS METOPROLOL TARTRATE (METOPROLOL TARTRATE) 100 Mg Tablet	Reported			01/13/15
100 MG PO Twice Daily, #60 TABLET HYDRALAZINE HCL (HYDRALAZINE HCL) 50 Mg Tablet	Reported			01/13/15
50 MG PO Twice Daily, #120 TABLET				

TRIAGE VITAL SIGNS

Date/Time	Systolic	Diastolic	Pulse	Resp	Pulse Ox	Temp	Pain Intensity	User
02/25/15 0351	177	97	86	2	94	98.7	8	CAMEROJO0...

OXYGENATION

Date/Time	Pulse Ox	Oxygen Delivery Method	User
02/25/15 0351	94	Room Air	CAMEROJO01, RN

VITAL SIGNS

Date/Time	Systolic	Diastolic	Pulse	Resp	Pulse Ox	Temp	Pain Intensity	User
02/25/15 0427	177	97	86	2	94	98.7	9	CAMEROJO0...
02/25/15 0527			86	21	97	98.2		CAMEROJO0...
02/25/15 0641	145	89	83	20	97	98.2	1	CAMEROJO0...

Date/Time	Temperature (Celsius)	User
02/25/15 0427	37.05852	CAMEROJO01, RN

ASSESSMENTS

02/25/15 0329 ED Past Medical History Adult *Collins,Bernadette, RN*

Past Medical History Y
Multiple Sclerosis N
Parkinson's Disease N
Seizures Y
Comment pt has not have one since age two
Glaucoma Y
Macular Degeneration N
Other HEENT Disorders no vision in left eye, getting eye injections in right eye
Pacemaker N
Internal Defibrillator (AICD) N
Arrhythmia N
Cardiac Catheterization/PCI N
Hypertension Y

Santa Rosa Memorial

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Status DEP ER **Weight** 56.000 kg **Dep'd** 02/25/15 0702
ED.Phys Brandwene,Elliott L **PC.Phys** Southwest Community,Health Cli

Palpitations N
Other Cardiovascular Disorders CHF
Asthma N
COPD N
Other Respiratory Disorders HX PERICARDIAL EFFUSIONS
Crohn's Disease N
Diverticulosis N
Esophageal Varices N
Pancreatitis N
Other GI Disorder partial pancreatectomy, gastroparesis
Dialysis Y
Comment AV Fisyula left upper arm
Prostate Problems N
Renal Failure Y
Comment CRF STAGE 3 KIDNEY DISEASE, dx'd in March 2014
Other Genitourinary Disorders GASTROPARESIS
LEFT UPPER ARM DIALYSIS SHUNT JAN/2015
Endometriosis N
Fibroids N
Epididymitis N
Other Reproductive Disorders tubal ligation
Arthritis,Rheumatoid N
Back Injury N
bromyalgia N
Other Musculoskeletal Disorders "NERVE PAIN"
Eating Disorder N
Panic Disorder N
Diabetes Mellitus Type 1 Y
Diabetes Mellitus Type 2 Y
Comment has been hospitlized for this many times
Hyperthyroidism N
Hypothyroidism N
Systemic Lupus Erythematosus N
Anemia Y
History Acquired Immunodeficiency Disease N
MRSA N
Bone N
Brain N
Breast N
Colorectal N
Leukemia N
Lymphoma N
Prostate N
Skin N
Chemotherapy N
Radiation Therapy N
Other Medical History kidney failure
Surgical History Y
Comment Partial pancreas removed as an infant
Cardiovascular Surgery Y

Santa Rosa Memorial

tient: GUTIERREZ,CYNTHIA 02/25/15 0341 **Room** **Acct#** SV0083448385
ge/Sex 33/F **DOB** 07/31/1981 **Height** 5 ft 3 in **Unit#** SM02706496
Status DEP ER **Weight** 56.000 kg **Dep'd** 02/25/15 0702
ED.Phys Brandwene,Elliott L **PC.Phys** Southwest Community,Health Cli

Heart Valve Replacement N
HEENT Surgery N
Endocrine Surgery Y
Comment partial pancreatectomy for hypoglycemia
Gastrointestinal Surgery Y
Comment PARTIAL PANCREAS REMOVAL
Cholecystectomy N
Genitourinary Surgery Y
Renal Transplant N
Orthopedic Surgery N
Joint Replacement N
Neurologic Surgery N
Reproductive Surgery Y
Gynecologic Surgery N
Mastectomy N
Transurethral Resection (TURP) N
Respiratory Surgery N
Tracheostomy N
Other Surgery N
Past Medical History Verified By Nurse With Patient/Family Y

02/25/15 0351 ED Adult Triage Assessment ***Cameron,Johnnie, RN***

History Of Present Illness pT REPORTS, "I HAVE HAD SHORTNESS OF BREATH SINCE 7PM LAST EVENING. Last dialysis one day ago. " Pt also c/o bilateral hand pain.

Informant Patient
Primary Language English
Interpreter Offered N
Means of Arrival Private Auto
Arrival From Home
Temp 98.7
Temperature (Calculated Celsius) 37.05852
Temperature Source Oral
Pulse 86
Resp 2
Pulse Ox 94
Oxygen Delivery Method Room Air
Systolic 177
Diastolic 97
Mean 123
Traveled Or Hospitalized Outside USA In Last 30 Days No
Reported Pain Pain Present
Pain Intensity 8
Height (Feet) 5
Height (Inches) 3
Height (Calculated Centimeters) 160.0
Height Measurement Method Stated
Weight (Kilograms) 56
Weight Source Stated
Is Patient Female? N

Santa Rosa Memorial

:ient: GUTIERREZ,CYNTHIA 02/25/15 0341 **Room** **Acct#** SV0083448385
e/Sex 33/F **DOB** 07/31/1981 **Height** 5 ft 3 in **Unit#** SM02706496
Status DEP ER **Weight** 56.000 kg **Dep'd** 02/25/15 0702
ED.Phys Brandwene,Elliott L **PC.Phys** Southwest Community,Health Cli

Currently Pregnant? N
Currently Breastfeeding? N
Priority 3 Urgent

02/25/15 0359 ED Patient Education Assessmnt — *Cameron,Johnnie, RN*
Barriers To Learning None
Focus Education To Patient
Education Topic Plan Of Care

02/25/15 0359 ED Focal Head To Toe Assessmnt — *Cameron,Johnnie, RN*
Eye Opening Spontaneously 4
Verbal Response Oriented and Converses 5
Motor Response Obeys Commands 6
Glasgow Coma Scale Total 15

02/25/15 0359 ED Screening Assessment — *Cameron,Johnnie, RN*
Last Tetanus Less Than 10 Years
Pressure Ulcer Prior To Admission N
Mode Of Transportation Ambulatory
Religious/Cultural Beliefs That May Affect Your Medical Care N
Recent Victim Of Physical/Emotional/Financial Abuse N
Do You Feel Safe Returning Home N
Barriers To Learning None
:story Of Falls No
:condary Diagnosis Yes
Ambulatory Aid None
IV/IV Access Yes
Gait Transferring Normal
Mental Status Oriented To Own Ability
Patient's Fall Risk Standard Fall Risk
Standard Interventions-All Patients Belongings Within Reach, Frequent Rounding, Bed Brakes On, Call Light In Reach, Bed In Lowest Position
Moderate/High Risk Falls Intervention Place near Nurses Station, Educate Pt/Family, Fall Risk Signage Placed, Room Free Of Clutter, Bed Alarm On While In Bed, Frequent Rounding, Bed Brakes On, Belongings Within Reach, Call Light In Reach
Smoking Status Former Smoker
Other Tobacco Use N
History Of Substance Use N
Are You Having Thoughts/Had Thoughts Of Hurting Yourslf N
Are You Having/Had Thoughts Of Hurting Someone Else N

02/25/15 0401 ED TB Screening — *Cameron,Johnnie, RN*
History Of Active Tuberculosis No
Weight Loss No
Anorexia No
Fatigue No
Cough No Cough

Santa Rosa Memorial

Client: GUTIERREZ,CYNTHIA 02/25/15 0341 **Room** **Acct#** SV0083448385
Age/Sex 33/F **DOB** 07/31/1981 **Height** 5 ft 3 in **Unit#** SM02706496
Status DEP ER **Weight** 56.000 kg **Dep'd** 02/25/15 0702
ED.Phys Brandwene,Elliott L **PC.Phys** Southwest Community,Health Cli

Fever No
Night Sweats No
Exposure No
Tuberculosis Precautions Standard Precautions

02/25/15 0402 ED Safety Rounding Assessment *Cameron,Johnnie, RN*
Safety Rounds Pt Resting In Bed
Patient Positioning/ Turning Turns Self
Patient Activity Resting In Bed
Safety Precautions Call/Assistance Education, ID Band Verified/Placed, Bed In Low Position, Door Open, Brakes Locked, Floors Clean Of Obstacles, Call Light Within Reach
Side Rails Up x2

02/25/15 0421 ED Event Assessment *Cameron,Johnnie, RN*
Event Assessment Comment Lab reports, pt has a BNP greater than 5000; Dr notified.

02/25/15 0427 ED Adult VS & Pain Assessment *Cameron,Johnnie, RN*
Temp 98.7
Temperature (Celsius) 37.05852
Temperature (Calculated Celsius) 37.05852
Temperature Source Oral
Pulse 86
Resp 2
Pulse Ox 94
Oxygen Delivery Method Room Air
Systolic 177
Diastolic 97
Mean 123
Location Right Arm
Blood Pressure Source Automatic Cuff
Blood Pressure Position Semi-Fowlers
Cardiac Monitoring Y
Cardiac Rhythm Sinus Rhythm
Reported Pain Pain Present
Location Modifier Left
Pain Location Hand
Pain Description Pins/Needles
Pain Intensity 9

02/25/15 0431 ED Event Assessment *Cameron,Johnnie, RN*
Event Assessment Comment Lab called and reported pt's glucose is 418; Dr notified.

02/25/15 0526 ED Safety Rounding Assessment *Cameron,Johnnie, RN*
Safety Rounds Pt Resting In Bed
Present At Bedside Family
Patient Positioning/ Turning Turns Self
Patient Activity Resting In Bed
Safety Precautions Call/Assistance Education, ID Band Verified/Placed, Bed In Low Position, Door Open, Brakes Locked, Floors Clean Of Obstacles

Santa Rosa Memorial

tient: GUTIERREZ,CYNTHIA 02/25/15 0341 **Room** **Acct#** SV0083448385
e/Sex 33/F **DOB** 07/31/1981 **Height** 5 ft 3 in **Unit#** SM02706496
Status DEP ER **Weight** 56.000 kg **Dep'd** 02/25/15 0702
ED.Phys Brandwene,Elliott L **PC.Phys** Southwest Community,Health Cli

Side Rails Up x2

02/25/15 0527 ED Adult VS & Pain Assessment — *Cameron,Johnnie, RN*
Temp 98.2
Temperature (Calculated Celsius) 36.78072
Temperature Source Oral
Pulse 86
Resp 21
Pulse Ox 97
Oxygen Delivery Method Nasal Cannula
Oxygen Flow Rate 2
Location Right Arm
Blood Pressure Source Automatic Cuff
Blood Pressure Position Semi-Fowlers
Cardiac Monitoring Y
Cardiac Rhythm Sinus Rhythm
Reported Pain Denies Pain
Location Modifier Left
Pain Location Hand

02/25/15 0615 ED Event Assessment — *Cameron,Johnnie, RN*
Event Assessment Comment Accu chel 318; Dr notified.

/25/15 0641 ED Adult VS & Pain Assessment — *Cameron,Johnnie, RN*
emp 98.2
Temperature (Calculated Celsius) 36.78072
Temperature Source Oral
Pulse 83
Resp 20
Pulse Ox 97
Oxygen Delivery Method Room Air
Systolic 145
Diastolic 89
Mean 107
Location Right Arm
Blood Pressure Source Automatic Cuff
Cardiac Monitoring Y
Cardiac Rhythm Sinus Rhythm
Reported Pain Pain Present
Location Modifier Left
Pain Location Hand
Pain Description Aching
Pain Intensity 1

02/25/15 0642 ED Safety Rounding Assessment — *Cameron,Johnnie, RN*
Safety Rounds Pt Resting In Bed
Patient Positioning/ Turning Turns Self
Patient Activity Resting In Bed
Safety Precautions Call/Assistance Education, ID Band Verified/Placed, Bed In Low Position, Door Open, Brakes Locked, Floors Clean Of Obstacles,

Santa Rosa Memorial

Patient: GUTIERREZ,CYNTHIA
Age/Sex 33/F DOB 07/31/1981
Status DEP ER
ED.Phys Brandwene,Elliott L

02/25/15 0341 Room
Height 5 ft 3 in
Weight 56.000 kg
PC.Phys Southwest Community,Health Cli

Acct# SV0083448385
Unit# SM02706496
Dep'd 02/25/15 0702

Call Light Within Reach
Side Rails Up x2

02/25/15 0700 ED Adult Disposition Assessmnt — *Cameron,Johnnie, RN*

Temp 98.2
Temperature (Celsius) 36.78072
Temperature (Calculated Celsius) 36.78072
Temperature Source Oral
Pulse 83
Resp 20
Pulse Ox 97
Oxygen Delivery Method Room Air
Oxygen Flow Rate 2
Systolic 145
Diastolic 89
Mean 107
Reported Pain Denies Pain
Discharge/Transfer Paperwork Sent With Patient Y
After Care Instructions Given To Patient
After Care Instructions Comprehension Verbalizes Understanding
Discharged Via Walked
Discharge Mode Private Auto

TREATMENTS

02/25/15 0413 ED IV Invasive Line Assessment — *Cameron,Johnnie, RN*

Location Right Hand
IV Line Type Peripheral IV
IV Site Observation/Evaluation Intact
Pre Hospitalization IV Start N
IV Gauge 22
Number Of Attempts 1

02/25/15 0414 ED EKG/ECG — *Cameron,Johnnie, RN*

EKG Results Reported To MD on duty

02/25/15 0422 ED Med Rec Completed — *Cameron,Johnnie, RN*

02/25/15 0659 ED Discontinue IV — *Cameron,Johnnie, RN*

Location Right Hand
Type Peripheral IV
Dressing Status Dressing Dry & Intact
IV Line Interventions Discontinued Intact

MEDICATIONS

Santa Rosa Memorial

ient: GUTIERREZ,CYNTHIA 02/25/15 0341 **Room** **Acct#** SV0083448385
e/Sex 33/F **DOB** 07/31/1981 **Height** 5 ft 3 in **Unit#** SM02706496
Status DEP ER **Weight** 56.000 kg **Dep'd** 02/25/15 0702
ED.Phys Brandwene,Elliott L **PC.Phys** Southwest Community,Health Cli

Medication

Sch Date-Time / Doc Date-Time	Ordered Dose / Given - Reason	Admin Dose / Site	User
HYDROmorphone Inj 1 mg/1 mL Amp (Dilaudid Inj) IM/ONCE/ONE			
02/25/15-0400	1 MG	1 MG	
02/25/15-0421	Y		Cameron,Johnnie

IM Injection Site: Right Dorsal Gluteal
Pain Scale Used: Verbal Numeric (0-10)
Pain Location Modifier:
Right
Pain Location: Hand
Pain Description:
Throbbing
Pain Intensity: 10
Reassessments:

02/25/15-0451			
02/25/15-0451	Y		Cameron,Johnnie

Pain Scale Used: Verbal Numeric (0-10)
Pain Location Modifier:
Left
Pain Location: Hand
Pain Description:
Aching
Pain Intensity: 2
Patient Reports Pain Level Controlled Or Tolerable: Y

Acknowledgements

Ack Date-Time	User
02/25/15-0421	Cameron,Johnnie

Ondansetron 4 mg Orally-Disintegrating Tab (Zofran ODT) PO/ONCE/ONE			
02/25/15-0400	4 MG	4 MG	
02/25/15-0421	Y		Cameron,Johnnie

Acknowledgements

Ack Date-Time	User
02/25/15-0421	Cameron,Johnnie

Insulin Regular 1 unit/0.01 mL (HumuLIN R) SUBCUT/ONCE/ONE			
02/25/15-0455	15 UNIT	15 UNIT	
02/25/15-0516	Y		Cameron,Johnnie

Blood Glucose: 418
Subcutaneous Injection Site: Right Posterior Arm

Acknowledgements

Ack Date-Time	User
02/25/15-0516	Cameron,Johnnie

HYDROmorphone Inj 1 mg/1 mL Amp (Dilaudid Inj) IVP/ONCE/ONE			
02/25/15-0605	1 MG	1 MG	

Santa Rosa Memorial

tient: GUTIERREZ,CYNTHIA 02/25/15 0341 **Room** **Acct#** SV0083448385
..ge/Sex 33/F **DOB** 07/31/1981 **Height** 5 ft 3 in **Unit#** SM02706496
Status DEP ER **Weight** 56.000 kg **Dep'd** 02/25/15 0702
ED.Phys Brandwene,Elliott L **PC.Phys** Southwest Community,Health Cli

Acknowledgements

Ack Date-Time / Doc Date-Time	Given - Reason	Site	User
02/25/15-0622	Y		Cameron,Johnnie

Pain Scale Used: Verbal Numeric (0-10)
Pain Location: Hand
Pain Description:
Aching
Pain Intensity: 5
Reassessments:

02/25/15-0652			
02/25/15-0659	Y		Cameron,Johnnie

Pain Scale Used: Verbal Numeric (0-10)
Pain Intensity: 0
Patient Reports Pain Level Controlled Or Tolerable: Y

Acknowledgements

Ack Date-Time	User
02/25/15-0622	Cameron,Johnnie

LAB RESULTS

..st	Date	Time	Result		Reference	Units
WBC	2/25/15	0350	7.8		(3.5-11.0)	10^3/uL
RBC	2/25/15	0350	2.66	L	(3.50-5.50)	10^6/uL
HGB	2/25/15	0350	7.7	L	(12.0-15.0)	g/dL
HCT	2/25/15	0350	24.2	# L	(36.0-45.0)	%
MCV	2/25/15	0350	91	#	(79-95)	fL
MCH	2/25/15	0350	29.1		(26.0-33.0)	pg
MCHC	2/25/15	0350	32.0		(32.0-36.0)	g/dL
RDW	2/25/15	0350	16.3	H	(11.0-14.0)	%
PLT	2/25/15	0350	172		(120-400)	THD/uL
MPV	2/25/15	0350	9.4		(7.4-10.4)	fL
Neutrophils %	2/25/15	0350	73.4	H	(34-64)	%
Lymphocytes %	2/25/15	0350	16.6	L	(19-48)	%
Monocytes %	2/25/15	0350	6.6		(3-9)	
Eosinophils %	2/25/15	0350	2.4		(0-7)	%
Basophils %	2/25/15	0350	1.0		(0-2)	%
Neutrophils #	2/25/15	0350	5.7	H	(2.5-5.6)	THD/uL
Lymphocytes #	2/25/15	0350	1.3		(0.8-3.5)	10^3/uL
Monocytes #	2/25/15	0350	0.5		(0.2-1.0)	THD/uL
Eosinophils #	2/25/15	0350	0.2		(0-0.5)	THD/uL
Basophils #	2/25/15	0350	0.1		(0-0.1)	THD/uL

Santa Rosa Memorial

Patient: GUTIERREZ,CYNTHIA 02/25/15 0341 **Room** **Acct#** SV0083448385
Age/Sex 33/F **DOB** 07/31/1981 **Height** 5 ft 3 in **Unit#** SM02706496
Status DEP ER **Weight** 56.000 kg **Dep'd** 02/25/15 0702
ED.Phys Brandwene,Elliott L **PC.Phys** Southwest Community,Health Cli

Test	Date	Time	Result		Reference	Units
Glucose	2/25/15	0350	418(A)	*H	(65-99)	mg/dL

(A) ****** CRITICAL VALUE ******
CALLED AND READ BACK BY:
WALLACCA01 on02/25/15(0429),TO CAMERON/ED
NURSE_____NOTIFIED DR._____DATE:_____TIME:_____
(Completed on hard copy only)
IF DR. NOT NOTIFIED REASON:_____
See also (B), (C)

Na	2/25/15	0350	137		(136-144)	mmol/L
K	2/25/15	0350	4.9		(3.6-5.1)	mmol/L
Cl	2/25/15	0350	96	L	(101-111)	mmol/L
CO2	2/25/15	0350	26		(22-32)	mmol/L
Anion Gap	2/25/15	0350	15.0	H	(3.0-11.0)	
BUN	2/25/15	0350	57	H	(8-20)	mg/dL
Creatinine	2/25/15	0350	3.9	H	(0.40-1.00)	mg/dL
Calcium	2/25/15	0350	8.0	L	(8.9-10.3)	mg/dL
TP	2/25/15	0350	6.8		(6.1-7.9)	gm/dL
Alb	2/25/15	0350	3.3	L	(3.5-4.8)	g/dL
Tbili	2/25/15	0350	0.5(B)		(0.3-1.2)	mg/dL

(B) --- 02/25/15 0756 ---
TBIL previously reported as:
< 0.1 L mg/dL

AST	2/25/15	0350	27		(15-41)	IU/L
ALT	2/25/15	0350	93	H	(14-54)	IU/L
Alk Phos	2/25/15	0350	290	H	(32-91)	IU/L
Globulin	2/25/15	0350	3.5		(2.3-3.5)	gm/dL
GFR Non-Af Am	2/25/15	0350	14(C)	L	(>60)	ml/min

(C) See (D), (E)
(D) Results suggest Kidney Stage 5 per NKF/DOQI guidelines
(E) **Note: As of 04/21/14 the eGFR will be calculated using the CKD-EPI equation**

Santa Rosa Memorial

tient: GUTIERREZ,CYNTHIA
e/Sex 33/F **DOB** 07/31/1981
Status DEP ER
ED.Phys Brandwene,Elliott L

02/25/15 0341 **Room**
Height 5 ft 3 in
Weight 56.000 kg

Acct# SV0083448385
Unit# SM02706496
Dep'd 02/25/15 0702
PC.Phys Southwest Community,Health Cli

Test	Date	Time	Result		Reference	Units
GFR Af Am	2/25/15	0350	17(F)	L	(>60)	ml/min
(F)	See (G), (H)					
CKMB Rapid	2/25/15	0350	5.1		(0.6-6.3)	ng/mL
Rap Trop I	2/25/15	0350	< 0.05(G)		(<0.05)	ng/mL

(G) 99% of normal subjects have values <0.04. The recommended threshold for acute MI is >0.40. Values between 0.04 and 0.39 often occur in patients with acute coronary syndromes and have been associated with an increased risk of coronary events.
Serial sampling is recommended to detect the temporal rise and fall of Troponin levels characteristic of an AMI.
These values should be interpreted in the context of the patient's clinical presentation.

NOTE: These assays were performed using the Biosite Triage Meter. Reference ranges may be different.

Santa Rosa Memorial

Client: GUTIERREZ,CYNTHIA 02/25/15 0341 **Room** **Acct#** SV0083448385
Age/Sex 33/F **DOB** 07/31/1981 **Height** 5 ft 3 in **Unit#** SM02706496
Status DEP ER **Weight** 56.000 kg **Dep'd** 02/25/15 0702
ED.Phys Brandwene,Elliott L **PC.Phys** Southwest Community,Health Cli

Test	Date	Time	Result	Reference	Units
BNPT	2/25/15	0350	> 5000(H) *H	(0-100)	pg/mL

(H) POSITIVE
****** CRITICAL RESULT******
CALLED AND BROADCAST TO CAMERON/EDE AT 0417,02/25/15 BY LAB WALLACCA01.
NURSE_____NOTIFIED DR._____DATE:_____TIME:_____
(Completed on hard copy only)
IF DR. NOT NOTIFIED REASON:_____
BNP LEVEL ADDITIONAL INTERPRETATIONS
0-100 PG/ML Highly unlikely that patient's symptoms result from systolic or diastolic dysfuntion.
101-200 PG/ML BNP greater than 100 pg/ml is considered positive and indicative of heart failure. LV Dysfunction with no acute CHF=141 (+/-31).
Severe Right Heart Failure, Pulm HTN, or large Pulm Embolus may equal 100-200 pg/ml.
201-479 PG/ML Almost always Left Heart Failure. AMI with CHF may have elevated levels; Positive BNP should not be viewed as excluding a diagnosis of AMI.
Equal to or greater than 480 PG/ML
Patients who present with dyspnea and BNP level equal to or greater than 480 have a nearly 30-fold increased risk for a cardiac event in the next 6 months.

ORDERS

Ordered	Procedure Name	Ordering Provider	E-Signed
02/25/15 0335	CBC w/ Differential	Brandwene,Elliott L, ACT	Yes
02/25/15 0335	CMP Comp Metabolic Panel CMP	Brandwene,Elliott L, ACT	Yes
02/25/15 0335	Cardiac Panel Baseline	Brandwene,Elliott L, ACT	Yes
02/25/15 0335	XR Chest 1V Portable	Brandwene,Elliott L, ACT	Yes
02/25/15 0335	EKG/ ECG	Brandwene,Elliott L, ACT	Yes
02/25/15 0400	HYDROmorphone Inj (Dilaudid...	Brandwene,Elliott L, ACT	Yes
02/25/15 0400	Ondansetron ODT (Zofran ODT)	Brandwene,Elliott L, ACT	Yes
02/25/15 0452	Insulin Regular (HumuLIN R)	Brandwene,Elliott L, ACT	Yes
02/25/15 0452	Insulin Regular (HumuLIN R)	Brandwene,Elliott L, ACT	N/A
02/25/15 0604	HYDROmorphone Inj (Dilaudid...	Brandwene,Elliott L, ACT	Yes
02/25/15 0808	Glucose Bedside	Brandwene,Elliott L, ACT	N/A

DEPARTURE

Primary Impression:
ESRD (end stage renal disease) on dialysis

Santa Rosa Memorial

.ent: GUTIERREZ,CYNTHIA 02/25/15 0341 **Room** **Acct#** SV0083448385
Age/Sex 33/F **DOB** 07/31/1981 **Height** 5 ft 3 in **Unit#** SM02706496
Status DEP ER **Weight** 56.000 kg **Dep'd** 02/25/15 0702
ED.Phys Brandwene,Elliott L **PC.Phys** Southwest Community,Health Cli

Secondary Impressions:
Chronic pain
Anemia
Neuropathy
Poorly controlled diabetes mellitus
Disposition: Discharge Home **Departure Date/Time:** 02/25/15 - 0702
Comment:
Condition: Stable

Referrals:
Southwest Community,Health Cli
751 Lombardi Ct
Santa Rosa, CA 95407
Phone: 707-547-2222 Fax: 707-547-2229

Pt Instructions: AFTERCARE, ED Chronic Pain, ED Chronic Renal Failure, Diabetic Neuropathy

Additional Instructions:
Please follow up at dialysis as scheduled tomorrow, and return to the emergency department sooner for worsening symptoms or any other concerns.

Care Plan:

arture Forms:

Departure Screen :

PRESCRIPTIONS

Prescription/Reported Meds	Type	Issued	Provider	Entered
HYDROCODONE BIT/ACETAMINOPHEN (NORCO 10-325 TABLET) Mg/325 Mg Tab 1 TAB PO Every 6 Hours As needed for PAIN, Moderate to Severe(4-10), #20 TAB	10 Rx	02/25/15	BRAEL001	02/25/15

CARE PROVIDERS

Staff History:
ED Physician:
02/25/15 0334 Brandwene,Elliott L, ACT
Practitioner:
Nurse:
02/25/15 0502 Cameron,Johnnie, RN

268

TRIAGE TIME	ROOM	EXAM RM TIME	COMPUTER OUT	ACUITY LEVEL	MODE OF ARRIVAL	CARRIED
2326	25	0728		(1) 2 3 4 5	WALKED W/C MEDICS UNIT#	(STRETCHER) OTHER

CHIEF COMPLAINT: Cardiac arrest

PAIN NOW ____/10 MAX ____/10 FLACC ____/10 NIPS ____/7 RADIATION ____

TIGHTNESS BURNING PRESSURE ACHING SHARP/STABBING THROBBING

ARRIVAL then DC cardiac pt. in waiting room
INTERVENTION PTA 2mg dilaudid, 4mg Zofran, 15units Humulin R ☐ SPINAL PRECAUTIONS

R.N. SIG

TIME: INITIALS:

NURSING ASSESSMENT (○ = pos / — = neg)

NEUROLOGIC ☐ N/A
Alert / Verbal / Pain / (Unresponsive)
Oriented to:
Person / Place / Time / Event
None / Age Appropriate
Cooperative / Agitated / Anxious
Combative / Lethargic / Aphasic
Cry Vigorous Weak Hi pitch
Weakness / Numbness
UE / LE R / L
Ms Tone WNL Hypo Hyper
Ant Font Soft/Flat Sunk Bulg

CARDIOVASCULAR ☐ N/A
Pink (Pale) Flushed
Warm / Cool
(Dry) Moist / Diaphoretic
JVD / Pedal Edema
Pulses
Rhythm PEA/rate 38
Cap Refill
Heart Sounds

RESPIRATORY ☐ N/A
Regular / Irregular Apneic
Labored / Unlabored
Clear R / L / Bilat
Crackles ☐ ☐ ☐
Rhonchi ☐ ☐ ☐
Wheezes ☐ ☐ ☐
Diminished ☐ ☐ ☐
Absent ☒ ☒ ☐
Stridor Grunting
Nasal Flaring / Retractions
Cough Nonprod / Prod

ABDOMEN / GU ☐ N/A
B.S Present / Absent
(Soft) Firm
Non-tender / Tender
(Distended)
N/V/D / Constipated
Urinary Δ
Dysuria
Vag. Bleed / Discharge
Jaundice

MUSCULOSKELETAL ☒ N/A
CSM Intact / Baseline / MAEW
Deformity / Abnormal Gait
Laceration
Bldg
Rash / Burn / Abrasion
Discolored
Ear Pulling R L
Pain R L

BP	P	R	PULSE OX	O_2 / RA	T.	ORAL RECTAL TEMPORAL	VISUAL AC	OD	OS	OU	LMP	PREG	LACT
212/128	150	52	100	bagging	94.4 ax		☐ CR ☐ UNC	20/___	20/___	20/___	G___	P___	AB___

SCREENINGS FOR: TB FALL RISK ISO
SUICIDE ABUSE
Learning Barriers
LEP ☐ INTERPRETER

☐ STATED ☐ MEASURED ☐ ESTIMATED ___ kg — BROSELOW

☐ STATED ☐ MEASURED ☐ ESTIMATED HT ___ — IMMUNIZATIONS / TETANUS

PMHx None HTN MI___ Stent Dysrhy___ HF PPM / AICD CABG___
Asthma COPD Pneu (Renal Failure) (Dialysis) Kidney Dis Migraine TIA CVA Trauma
Alz/Dementia Seizure NIDDM (IDDM) Thyroid GERD PUD Pancreatitis Liver Dis
Psych___ Appy Chole Hyster Hepatitis HIV CA Recent Inf
Soc Hx ETOH Rec Drugs Smoker ___PPD Lives Alone___

IV #1 TIME 0727 — 1 # Attempts
DISCONTINUED CATH INTACT ☐
INIT MH SITE (R)AC SIZE 20g

IV #2 TIME ___ — ___ # Attempts
DISCONTINUED CATH INTACT ☐
INIT ___ SITE ___ SIZE ___

IV FLUIDS

TIME	BAG #	VOLUME TYPE	BOLUS TIME	BOLUS VOLUME	RATE	RN INIT	VOL INFUSED	TIME DONE

ENDOTRACHEAL TUBE TIME 0728
INSERTED BY Lauterbach
SIZE 8.0ett/24 /CM LIPS
PLACEMENT CONFIRMED (ETCO2)
EID (BS) (RISE/FALL) CXR

VENTILATOR MODE ACDC
RATE 14
FiO_2 100 Vt 400
PEEP 5 PS ___

NASOGASTRIC TUBE TIME 0759
INSERTED BY Deb Bishop
SIZE 18 PLACEMENT ✓ ___
COLOR reddish/brown
GUIAC: + − RES VOL. 20

URINARY CATHETER TIME 0815
INSERTED BY Deb Bishop
CATH SIZE 16 ☒ URINE METER
APPEARANCE ☐ CLEAR ☒ CLOUDY ☐ GROSS BLOOD
COLOR yellow RES VOL. ___

INTAKE

TIME	TYPE	AMOUNT
TOTAL INTAKE		mL

OUTPUT

TIME	TYPE	AMOUNT
TOTAL OUTPUT		mL

URINE DIP: Leuko ___ pH ___ Bilirubin ___ Nitrates ___ Blood ___ Glucose ___ Urobil ___ Spec Gr ___ Protein ___ Ketone ___ Initials
CLEAN / CATH

Santa Rosa Memorial Hospital
ST. JOSEPH HEALTH SYSTEM

PATIENT CARE RECORD
EMERGENCY DEPARTMENT

PATIENT ID SV83448563

CAT REG ER
GUTIERREZ, CYNTHIA
SM02706496 07/31/1981 33 F
02/25/15 NSMED
Lauterbach, Stewart A

SRMH(2) 19670

000243

MD TIME	ORDER SETS	TIME/INT	Rad / Int
	☐ Abd Pain < 50		
	☐ Abd Pain > 50 CT per MD ord		
	☐ Chest Pain < 30 PA/Lat		
	☐ Chest Pain > 30 ☐ pCXR ☐ PA/LAT		
	☐ CVA CTH pCXR		
	☐ Sepsis Adult ☐ pCXR ☐ PA/LAT		
	☐ OD/Psych		
	☐ Vag Bleed		
	☐ Hip Fracture Hip/Pel pCXR		
	☐ Seizure, Afeb, Recur		
	☑ GI Bleed		
	☐ Syncope > 35 ☐ pCXR ☐ PA/LAT		
	☐ Syncope < 35		
	☐ CSF Fluid		

OTHER ORDERS

MD TIME	RADIOLOGY	TIME/INT	Rad/INT
	☐ CXR Port Pa/Lat		
	☐ C-Spine AP/Lat		
	☐ Pelvis AP		
	☐ Hip/Pelvis. R L		

CT

	☐ Brain (NC). ALOC HA CVA		
	☐ Chest: ☐ Cont ☐ NC		
	AO Dissec PE Trauma		
	☐ Spine		
	☐ ABD/PEL		
	AAA Appy Stone Diverte		
	Remark:		
	Contrast. ☐ None ☑ IV ☐ ORAL ☐ 1 hour ☐ 2 hour		

US

	☐ ABD:		
	☐ Scrotal:		
	☐ DVT: R L B		
	☐ Pelvis.		
	IUP Retain Prod Ovar Tors		

MD TIME	LABORATORY/OTHER	TIME/INT
	☐ CBC	
	☐ BMP	
	☐ CMP	
	☐ BNP	
	☐ HCG: Quan Qual	
	☐ Lipase	
	☐ PT/INR	
	☐ D-Dimer	
	☐ Chlam/GC PCR	
	☐ Cardiac Markers	
	☐ ABG	
	☐ DSU	
	☐ Urine Clean Cath	
	Dip UA C&S	
	☐ Bld Cult: 1 2 3	
	☐ ECG + Rhythm St	
	☐ Repeat ECG	

BBK

	Hold Clot	
	Type/Screen	
	Type/Cross	
	(PC) x _____ Units	
	(PLT) x _____ Units	
	(FFP) x _____ Units	

NOTES 0742- BS is 200 on bedside glucometer MN RN
0745 - Late entry - Patient was discharged this am and went out to waiting room. Pt. told staff she was going to sit in waiting room. Pt then went into cardiac arrest MN RN

☐ Questionable diagnostic picture, delay in the diagnosis of pneumonia at the time of admission

MD CHART COMPLETE Y N

I have reviewed the patient's list of home medications to determine their impact on this visit Any changes to those medications are reflected in the discharge instructions.

MD SIGNATURE TIME ☐ TEMPLATE ☐ DICTATE # _____

PATIENT DISPOSITION:
TIME _____
INITIALS _____
WHEELCHAIR/AMBULATORY
STRETCHER/CARRIED

DISCHARGE ☐ HOME
☐ OTHER _____
☐ VITALS/PAIN
☐ INSTRUCTIONS REC'D AND VERBALIZED UNDERSTANDING
☐ INTERPRETER _____

ADMIT
TO _____
REPORT TO _____
REPORT TIME _____
☐ BELONGINGS LIST DONE

OTHER:
☐ TRANSFER TO: _____
☐ CUSTODY ☐ EXPIRED
☐ AMA ☐ MORTUARY
☐ BEF/LWOT ☐ SRMH MORGUE
☐ CORONER

Initials	Signature	Initials	Signature
MN	MN RN		

PATIENT IDENTIFICATION

SV83448563

CAT REG ER
GUTIERREZ,CYNTHIA
SM02706496 07/31/1981 33 F
02/25/15 NSMED
Lauterbach,Stewart A
02/25/15 NSMED 150 F

Santa Rosa Memorial Hospital
ST JOSEPH HEALTH SYSTEM

2297 (4/20/09) Page 2 of 2

SRMH(2) 19671

000244

Pg of

	TIME	0734	0742	0750	0800	0815	0830					NURSING NOTES
CARDIAC	NIBP ABP BP	212/128	210/119	166/86	167/96	159/85	145/77					0828-Lisa from lab. Critical lab BNP >5000. Pt to CT-SS
	MAP		133	108	113	113	97					0837-Rpt to RN Nancy, pt to ICU Rm 268 from CT-SS
	HR	150	152	111	103	94	88					
	RHYTHM	ST	ST	ST	ST	SR	SR					
RESP	RATE	52	28	14	14	16	14					
	O_2 SAT	100	100	100	100	100	100					
	RA NRM NC L/min	Vent	Vent	Vent	Vent	Vent	V					
TEMP	ORAL TEMPORAL RECTAL			99.4 ax								
PAIN	/10											
INEURO	EYE	1	1	1	1	1	1					
	VERBAL	1	1	1	1	1	1					
	MOTOR	1	1	1	1	1	1					
	GCS	3	3	3	3	3	3					
	PUPILS R SIZE/RXN		3/Fixed	3/Fixed								
	PUPILS L SIZE/RXN		4/Fixed	4/Fixed								
DRIPS	Propofol mcg/kg/min			20								
OTHER												

PUPIL SIZE: MM

o o o ◯ ◯

2 3 4 5 6

GLASGOW COMA SCALE

EYE OPENING	VERBAL		MOTOR	
4 - SPONTANEOUS	5 - ORIENTED	2 - INCOMP. SOUNDS	6 - OBEYS	3 - ABD. FLEXION
3 - TO SPEECH	4 - CONFUSED		5 - LOCALIZES	2 - EXT. RESPONSE
2 - TO PAIN	3 - INAPP. WORDS	1 - NONE	4 - WITHDRAWS	1 - NONE
1 - NONE				

TIME		PHYSICIAN ORDERS	TIME DONE	INIT	TREATMENT RESPONSE
0750	1	Propofol per protocol	0750	DB	20mcg/Kg/min
	2				
	3				
	4				
	5				
	6				
	7				
	8				
	9				
	10				

All orders are a one time frequency, unless otherwise written. Ordered By: MD

Initials	Signature	Initials	Signature
MM	M Fuy RN	DB	D Bishop RN

Santa Rosa Memorial Hospital
ST. JOSEPH HEALTH SYSTEM

PATIENT MONITORING RECORD

7010-006 (9/16/08)

SV83448563

CAT REG ER
GUTIERREZ, CYNTHIA
SM02706496 07/31/1981 33 F
02/25/15 NSMED
Lauterbach, Stewart A

700245

SRMH(2) 19672

268

TRIAGE TIME	ROOM	EXAM RM TIME	COMPUTER OUT	ACUITY LEVEL
2726	25	0728		(1) 2 3 4 5

MODE OF ARRIVAL WALKED W/C CARRIED STRETCHER
MEDICS UNIT# _____ OTHER _____

CHIEF COMPLAINT: Cardiac arrest

PAIN NOW _____/10 MAX _____/10 TIGHTNESS BURNING
FLACC _____/10 NIPS _____/7 PRESSURE ACHING
RADIATION _____ SHARP/STABBING THROBBING

INTERVENTION PTA: AM visit then DC asd pt. in waiting room 2mg dilaudid, 4mg Zofran, 15units Humulin R ☐ SPINAL PRECAUTIONS

R.N. SIG

TIME: INITIALS:

NURSING ASSESSMENT ○ = pos / — = neg

NEUROLOGIC ☐ N/A
Alert / Verbal / Pain / (Unresponsive)
Oriented to:
Person / Place / Time / Event
None / Age Appropriate
Cooperative / Agitated / Anxious
Combative / Lethargic / Aphasic
Cry Vigorous Weak Hi pitch
Weakness / Numbness
UE / LE R / L
Ms Tone WNL Hypo Hyper
Ant Font Soft/Flat Sunk Bulg

CARDIOVASCULAR ☐ N/A
Pink (Pale) Flushed
Warm / Cool
(Dry) Moist / Diaphoretic
JVD / Pedal Edema
Pulses
Rhythm PEA/rate 38
Cap Refill
Heart Sounds

RESPIRATORY ☐ N/A
Regular / Irregular
Labored / Unlabored Apneic
Clear R / L / Bilat
Crackles ☐ ☐ ☐
Rhonchi ☐ ☐ ☐
Wheezes ☐ ☐ ☐
Diminished ☐ ☐ ☐
Absent ☒ ☒ ☐
Stridor Grunting
Nasal Flaring / Retractions
Cough Nonprod / Prod

ABDOMEN / GU ☐ N/A
B.S. Present / Absent
(Soft) / Firm
Non-tender / Tender
(Distended)
N / V / D / Constipated
Urinary △
Dysuria
Vag. Bleed / Discharge
Jaundice

MUSCULOSKELETAL ☒ N/A
CSM Intact / Baseline / MAEW
Deformity / Abnormal Gait
Laceration
Bldg
Rash / Burn / Abrasion
Discolored
Ear Pulling R L
Pain R L

BP	P	R	PULSE OX	O_2 / RA	T	ORAL / RECTAL / TEMPORAL
212/128	150	52	100	bag/mask	94.4 ax	

VISUAL AC: OD OS OU
☐ CR
☐ UNC 20/____ 20/____ 20/____

LMP PREG LACT
G_____ P_____ AB_____

SCREENINGS FOR: TB FALL RISK ISO
SUICIDE ABUSE
Learning Barriers
LEP ☐ INTERPRETER

☐ STATED ☐ MEASURED ☐ ESTIMATED WT. ____ kg BROSELOW

☐ STATED ☐ MEASURED ☐ ESTIMATED HT. ____ IMMUNIZATIONS / TETANUS

PMHx None HTN MI_____ Stent Dysrhy_____ HF PPM / AICD CABG_____
Asthma COPD Pneu (Renal Failure) (Dialysis) Kidney Dis Migraine TIA CVA Trauma
Alz/Dementia Seizure NIDDM (IDDM) Thyroid GERD PUD Pancreatitis Liver Dis
Psych_____ Appy Chole Hyster Hepatitis HIV CA Recent Inf
Soc Hx ETOH Rec Drugs Smoker____PPD Lives Alone_____

IV #1 TIME 0727 — 1 # Attempts
DISCONTINUED CATH INTACT ☐
INIT [illegible] SITE (RAC) SIZE 20g

IV #2 TIME _____ — ____ # Attempts
DISCONTINUED CATH INTACT ☐
INIT _____ SITE _____ SIZE _____

IV FLUIDS

TIME	BAG #	VOLUME TYPE	BOLUS TIME	BOLUS VOLUME	RATE	RN INIT	VOL. INFUSED	TIME DONE

INTAKE

TIME	TYPE	AMOUNT

TOTAL INTAKE _____ mL

OUTPUT

TIME	TYPE	AMOUNT

TOTAL OUTPUT _____ mL

ENDOTRACHEAL TUBE TIME 0728
INSERTED BY Lauterbach
SIZE 8.0 eth / 24 /CM LIPS
PLACEMENT CONFIRMED ETCO2
EID (BS) (RISE/FALL) CXR

VENTILATOR MODE ACDC
RATE 14
FiO_2 100 Vt 400
PEEP 5 PS _____

NASOGASTRIC TUBE TIME 0759
INSERTED BY Deb Bishop
SIZE 18 PLACEMENT ✓ _____
COLOR reddish/brown
GUIAC: + − RES VOL. 20

URINARY CATHETER TIME 0815
INSERTED BY Deb Bishop
CATH SIZE 16 ☒ URINE METER
APPEARANCE ☐ CLEAR ☒ CLOUDY ☐ GROSS BLOOD
COLOR yellow RES VOL. _____

URINE DIP: Leuko _____ pH _____ Bilirubin _____
Nitrates _____ Blood _____ Glucose _____
Urobill _____ Spec Gr _____ Initials

CLEAN / CATH

SV83448563

PATIENT IDENTIFI

CAT REG ER
GUTIERREZ, CYNTHIA
SM02706496 07/31/1981 33 F
02/25/15 NSMED
Lauterbach, Stewart A

Santa Rosa Memorial Hospital
ST. JOSEPH HEALTH SYSTEM

PATIENT CARE RECORD
EMERGENCY DEPARTMENT

000246

SRMH(2) 19674

MD TIME	ORDER SETS	TIME/INT	Rad / Int
	☐ Abd Pain < 50		
	☐ Abd Pain > 50 CT per MD ord		
	☐ Chest Pain < 30 PA/Lat		
	☐ Chest Pain > 30 ☐ pCXR ☐ PA/LAT		
	☐ CVA CTH pCXR		
	☐ Sepsis Adult ☐ pCXR ☐ PA/LAT		
	☐ OD/Psych		
	☐ Vag Bleed		
	☐ Hip Fracture Hip/Pel pCXR		
	☐ Seizure, Afeb, Recur		
	☐ GI Bleed		
	☐ Syncope > 35 ☐ pCXR ☐ PA/LAT		
	☐ Syncope < 35		
	☐ CSF Fluid		

OTHER ORDERS

MD TIME	RADIOLOGY	TIME/INT	Rad/INT
	☐ CXR: Port Pa/Lat		
	☐ C-Spine AP/Lat		
	☐ Pelvis AP		
	☐ Hip/Pelvis: R L		

CT

	☐ Brain (NC): ALOC HA CVA		
	☐ Chest: ☐ Cont ☐ NC		
	AO Dissec PE Trauma		
	☐ Spine		
	☐ ABD/PEL		
	AAA Appy Stone Divertic		
	Remark:		
	Contrast: ☐ None ☐ IV ☐ ORAL ☐ 1 hour ☐ 2 hour		

US

	☐ ABD:		
	☐ Scrotal:		
	☐ DVT: R L B		
	☐ Pelvis:		
	IUP Retain Prod Ovar Tors		

MD TIME	LABORATORY/OTHER	TIME/INT
	☐ CBC	
	☐ BMP	
	☐ CMP	
	☐ BNP	
	☐ HCG: Quan Qual	
	☐ Lipase	
	☐ PT/INR	
	☐ D-Dimer	
	☐ Chlam/GC PCR	
	☐ Cardiac Markers	
	☐ ABG	
	☐ DSU	
	☐ Urine: Clean Cath	
	Dip UA C&S	
	☐ Bld Cult: 1 2 3	
	☐ ECG + Rhythm St	
	☐ Repeat ECG	

BBK

	Hold Clot
	Type/Screen
	Type/Cross
(PC) x	Units
(PLT) x	Units
(FFP) x	Units

NOTES 0742- BS is 200 on bedside glucometer. ZZ, RN

0745 - Late entry - Patient was discharged this am and went out to waiting room. Pt. told staff she was going to sit in waiting room. Pt. then went into cardiac arrest ZZ, RN

☐ Questionable diagnostic picture, delay in the diagnosis of pneumonia at the time of admission

MD CHART COMPLETE Y N

I have reviewed the patient's list of home medications to determine their impact on this visit. Any changes to those medications are reflected in the discharge instructions.

MD SIGNATURE TIME ☐ TEMPLATE ☐ DICTATE #

PATIENT DISPOSITION

TIME

INITIALS

WHEELCHAIR/AMBULATORY
STRETCHER/CARRIED

DISCHARGE ☐ HOME
☐ OTHER
☐ VITALS/PAIN
☐ INSTRUCTIONS REC'D AND VERBALIZED UNDERSTANDING
☐ INTERPRETER

ADMIT
TO
REPORT TO
REPORT TIME
☐ BELONGINGS LIST DONE

OTHER:
☐ TRANSFER TO:
☐ CUSTODY ☐ EXPIRED
☐ AMA ☐ MORTUARY
☐ BEF/LWOT ☐ SRMH MORGUE
☐ CORONER

Initials	Signature	Initials	Signature
MM	ZZ, RN		

PATIENT IDENTIFICATION

SV83448563

CAT REG ER
GUTIERREZ,CYNTHIA
SM02706496 07/31/1981 33 F
02/25/15 NSMED
Lauterbach,Stewart A
02/25/15 NSMED

Santa Rosa Memorial Hospital
ST JOSEPH HEALTH SYSTEM

2297 (4/20/09) Page 2 of 2

SRMH(2) 19675

000247

Pg of

	TIME	0734	0736	0750	0800	0815	0830
CARDIAC	NIBP ABP BP	212/128	210/114	166/86	162/96	159/85	145/77
	MAP		133	108	113	113	97
	HR	150	152	111	103	94	88
	RHYTHM	ST	ST	ST	ST	SR	SR
RESP	RATE	52	28	14	14	16	14
	O_2 SAT	100	100	100	100	100	100
	RA NRM NC L/min	Vent	Vent	Vent	Vent	Vent	V
TEMP	ORAL TEMPORAL RECTAL			94.1 ax			
PAIN	____/10						
NEURO	EYE	1	1	1	1	1	1
	VERBAL	1	1	1	1	1	1
	MOTOR	1	1	1	1	1	1
	GCS	3	3	3	3	3	3
	PUPILS R SIZE		3	3			
	PUPILS R RXN		Fixed	Fixed			
	PUPILS L SIZE		4	4			
	PUPILS L RXN		Fixed	Fixed			
IV SITES	Propofol mcg/kg/min			20			
OTHER							

NURSING NOTES

0832 - Lisa from lab. Critical lab BNP > 5000. Pt to CT - 0833 - Rpt to RN Nancy Pt to ICU Rm 261 from CT — 0835

PUPIL SIZE: MM
2 3 4 5 6

GLASGOW COMA SCALE

EYE OPENING	VERBAL	MOTOR
4 - SPONTANEOUS	5 - ORIENTED	6 - OBEYS
3 - TO SPEECH	4 - CONFUSED	5 - LOCALIZES
2 - TO PAIN	3 - INAPP. WORDS	4 - WITHDRAWS
1 - NONE	2 - INCOMP. SOUNDS	3 - ABD. FLEXION
	1 - NONE	2 - EXT. RESPONSE
		1 - NONE

TIME	PHYSICIAN ORDERS	TIME DONE	INIT	TREATMENT RESPONSE
0750	1 Propofol per protocol	0750	DB	20mcg/Kg/min.
	2			
	3			
	4			
	5			
	6			
	7			
	8			
	9			
	10			

All orders are a one time frequency, unless otherwise written. Ordered By: MD

Initials	Signature	Initials	Signature
MM		DB	D Bishop RN

Santa Rosa Memorial Hospital
ST. JOSEPH HEALTH SYSTEM

PATIENT MONITORING RECORD

7010-006 (9/16/08)

SV83448563

CAT REG ER
GUTIERREZ, CYNTHIA
SM02706496 07/31/1981 33 F
02/25/15 NSMED
Lauterbach, Stewart A

000248

SRMH(2) 19676

SANTA ROSA MEMORIAL HOSPITAL

CODE BLUE RECORD

SV83448563

DATE:	TIME:	LOCATION OF ARREST:	DISCOVERED BY:	TIME CPR BEGAN:	TEAM ARRIVAL TIME:
2/25/15		ER waiting room	Bystander	0726	0726

CAT REG ER
GUTIERREZ, CYNTHIA
SM02706496 07/31/1981 33 F
02/25/15 NSMED
Lauterbach, Stewart A

TYPE OF ARREST: [X] Cardiac [ ] Asystole [ ] Witnessed [X] Unwitnessed [ ] Respiratory [ ] Vent. Fib. [ ] Vent. Tach [ ] Unknown

ENDOTRACHEAL TUBE: Intubation Route: [ ] NASAL [X] ORAL Time: 0728 Size: 8 cm at lips: 24cm Intube By: Lauterbach

O2 THERAPY PRIOR TO ARREST: N/A

O2 THERAPY POST ARREST: Bag valve mask / ventilator

PATIENT'S ADMITTING DIAGNOSIS: Code blue

Mode of Vent: [X] bag / mask [X] ventilator

TELEMETRY: [X] YES [ ] NO

PT. ADDRESSOGRAPH

PRECIPITATING EVENTS: Patient was discharged and was sitting out in waiting room. Pt. went into Cardiac arrest in waiting room. CPR en route to ER room by ER nursing staff

TIME	RHYTHM	HR	RESP	Blood Pressure	BOLUS - DRUG AMOUNT: Amiodarone	Atropine	CaCl	Cardizem	Epi	Lidocaine	$NaHCO_3$	NTG	DEFIBRILLATION: ENERGY	RHYTHM PRE	RHYTHM POST	BLOOD GASES: TIME	pH	pO_2	pCO_2	K+	PROCEDURES/ TIME PERFORMED/ LOCATION
0728	PEA	38	Intubated				1amp 0733				1amp 0733			CPR in progress							[X] ER room 0759
0734	ST	150	intubated 52	212/128					1amp 0734	+pulses/+heart movement with U/S											[X] Foley
0736	ST	152	28	210/114																	[ ] Pericardiocentesis
																					[ ] Chest Tube
																					[ ] Arterial Line
																					[ ] Central Line
																					[X] Other IV 0727
																					[ ] External Pacemaker
																					[ ]
																					[ ]
																					[ ]

OTHER:

IV MEDICATION DRIPS

MEDICATION	START TIME	RATE	MEDICATION	START TIME	RATE
EPINEPHRINE 2mg/250mL D_5W			NTG 50mg/250mL D_5W		
NIPRIDE 50mg/250mL D_5W			AMIODARONE 200mg/500mL D_5W		
LIDOCAINE 2GM/250mL D_5W					
DOPAMINE 400mg/250mL D_5W					

TIME RESUSCITATION ENDED: 0736

Patient: (SURVIVED) / EXPIRED (CIRCLE ONE)

PATIENT TRANSFERRED TO:

Family: PRESENT / NOTIFIED BY PHONE (CIRCLE ONE)

TEAM MEMBER SIGNATURES

CODE PHYSICIAN: Lauterbach

ANESTHESIA:

RECORDING NURSE:

MEDICATION NURSE: Chad Davis RN

RESPIRATORY THERAPIST: Dan Bradford

13642 (10/25/04)

SRMH(2) 19692

000269

Santa Rosa Memorial Hosp.
1165 Montgomery Dr
Santa Rosa, CA 95405
707-546-3210

MRN#: SM02706496
Patient: GUTIERREZ,CYNTHIA
Report Status: Signed
Documented By: LAUST001
Documented Date: 02/25/15 0742

Account#: SV0083448563
Report Type: EDPHYRPT
Report Mnemonic: PHY.ER
Report#: 0225-0094
Facility: NSM

Emergency Department Report

ADDENDUM
02/26/15

Addendum: Lauterbach,Stewart A on 2/26/15 @ 11:10

I failed to note in the note below that this patient immediately after the patient was intubated, a large piece of food was aspirated from the ET tube. This was removed by Dan, our respiratory therapist. I question if she could have had an aspiration leading to hypoxia, and the collapse.

This Addendum is not considered FINAL until Signed by a Physician

Authenticated By:
<Electronically signed by Stewart A Lauterbach MD> 02/26/15 1113

Lauterbach, Stewart A MD

cc:

History of Present Illness

HPI

Service date
2/25/15
Time Seen by MD: 07:41
Chief complaint: full arrest, refer to code record
This is a 33y/o female that was seen here overnight in the ER, discharged this morning. She was sitting out in the waiting room when a patient's family member noticed she looked unresponsive. ER staff responded immediately and started CPR. Patient has a known history of ESRD. HPI is otherwise limited secondary to patient condition.
Location: hospital
Onset/Duration/Timing: started approximately - 0720 this morning
Related symptoms: : - unknown

Past Medical History

Coded Allergies:
No Known Allergies (Unverified , 2/25/15)
per huisband, no known allergies

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Active Scripts
Hydrocodone Bit/Acetaminophen (Norco 10-325 Tablet)10 Mg/325 Mg Tab1 Tab PO Q6HR PRN (PAIN, Moderate to Severe(4-10)) #20 TAB
Prov:Brandwene,Elliott L 2/25/15
Oxycodone Hcl/Acetaminophen (Percocet 10-325 Mg Tablet)1 Each Tablet1 Tab PO Q4HR #10 TAB
Prov:Brandwene,Elliott L 2/6/15
Hydrocodone Bit/Acetaminophen (Norco 5-325 Tablet)5 Mg/325 Mg Tab1-2 Tab PO Q6H PRN (PAIN, Moderate to Severe(4-10)) #15 TAB
Prov:Allred,Kendall S 2/1/15
Metoclopramide Hcl (Reglan)10 Mg Tab10 Mg PO ACHS #120 TAB Ref 3
Prov:Altaf,Mujeeb 1/22/15
Hydrocodone Bit/Acetaminophen (Norco 5-325 Tablet)5 Mg/325 Mg Tab1 Tab PO Q6H PRN (PAIN, Mild (1-3)) #30 TAB Ref 0
Prov:Quang,Angela M 1/16/15
Amlodipine Besylate (Norvasc)5 Mg Tab5 Mg PO DAILY 30 Days
Prov:Junck,Daniel L 1/5/15
Atorvastatin Calcium (Lipitor)20 Mg Tab20 Mg PO QPM #30 TAB Ref 0
Prov:Quang,Angela M 12/17/14
Furosemide (Lasix)80 Mg Tablet80 Mg PO DAILY #30 TAB
Prov:Altaf,Mujeeb 12/3/14
Ondansetron (Zofran Odt)4 Mg Tab.rapdis4 Mg PO BID PRN (NAUSEA/VOMITING) #10 TAB
Prov:Muller,Ridgely O 11/2/14

Reported Medications
Hydralazine Hcl 50 Mg Tablet50 Mg PO BID #120 TAB
1/13/15
Metoprolol Tartrate 100 Mg Tablet100 Mg PO BID #60 TAB
TO TAKE AM OF SURGERY
1/13/15
Brimonidine Tartrate (Brimonidine Tartrate 0.2%)5 Ml Drops1 Drop BOTH EYES TID #5 ML
6/7/14
Timolol Maleate (Timolol Maleate Ophth Soln 0.5%)10 Ml Drops1 Drop BOTH EYES BID #10 ML
6/7/14
Latanoprost 2.5 Ml Drops1 Drop BOTH EYES QPM #2.5 ML
6/7/14

Travel History
Travel and/or hospitalization outside the US in the last 30 days?
Past medical records: reviewed
Endocrine history: DM type 2, hypothyroidism
Renal history: renal failure, dialysis
Other pertinent history: chronic pain
Family history of: DM
Smoking Status: Never A Smoker
History Of Substance Abuse: No

Review of systems
ROS unobtainable due to: acuity of condition

Physical Exam
Exam
Vital signs

Initial Vital Signs

Patient: GUTIERREZ,CYNTHIA
Adm Phys: Kang,Hyun
MRN#: SM02706496

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Date Time	Temp	Pulse	Resp	B/P	Pulse Ox	O2 Delivery	O2 Flow Rate	FiO2
2/25/15 08:16		116			100			100
2/25/15 08:45	97.7		14	126/63		Ventilator		

Exam limitations: clinical condition
General appearance: unresponsive, : - uremic frost
Head/ENT: atraumatic, no airway obstruction
Respiratory: lungs clear - after intubation, no spontaneous respirations
Cardiovascular: : - pulseless rhythm
Abdomen: soft, no distention
Extremities: no signs of trauma
Neurologic: unresponsive

Glasgow Coma Scale
Eye opening: 1=none
Verbal response: 1=none
Motor response: 1=no response

Data
Vital Signs

Date Time	Temp	Pulse	Resp	B/P	Pulse Ox	O2 Delivery	O2 Flow Rate	FiO2
2/25/15 08:45	97.7	88	14	126/63	100	Ventilator		40
2/25/15 08:16		116			100			100

Medications Administered
Given in ED

Medications Administered

Medications (Trade)	Dose Ordered	Sig/Sch	Start Time Stop Time	Status	Last Admin Dose Admin
Pantoprazole Sodium/Sodium Chloride (Protonix Inj/ Normal Saline)	100ml @ 10 mls/hr	Q10H	2/25/15 08:10		2/26/15 04:41 10 MLS/HR
Propofol	100ml @ 0 mls/hr	Q0M PRN	2/25/15 08:08		2/26/15 08:21 0 MLS/HR

Diagnostics & Interpretation
X-RAY (Interpreted by EP) :
Read by: Radiologist
X-RAY type: chest
# of views: 1
X-RAY positive findings: : - et low - called nurse - inc dens infilts lll, rul, rll.. stable cm, rt jug
CT :
CT findings
Head - negative acute

Patient: GUTIERREZ,CYNTHIA
Adm Phys: Kang,Hyun
MRN#: SM02706496

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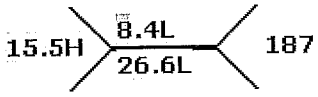
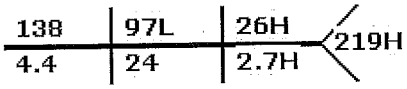
Result Diagram:
2/26/15 0614



2/26/15 0614



Lab Results

Laboratory Tests

Test	2/25/15 07:41	2/25/15 07:47	2/25/15 07:50	2/25/15 08:48
POC Glucose	200 H mg/dL (65-99)			101 H mg/dL (65-99)
WBC		12.2 H 10^3/uL (3.5-11.0)		
RBC		2.78 L 10^6/uL (3.50-5.50)		
Hgb		8.1 L g/dL (12.0-15.0)		
Hct		26.0 L % (36.0-45.0)		
MCV		93 fL (79-95)		
Plt Count		163 THD/uL (120-400)		
Manual Differential		Not Indicated		
Seg Neutrophils %		52.9 % (34-64)		
Lymphocytes %		36.3 % (19-48)		
Monocytes %		7.0 (3-9)		
Eosinophils %		2.2 % (0-7)		
Basophils %		1.6 % (0-2)		
Anisocytosis		2+		
PT		14.5 Sec. (11.9-14.8)		
INR		1.10 (0.6-1.4)		
PTT		25.8 SEC (23.0-36.3)		
Sodium		140 mmol/L (136-144)		
Potassium		4.3 mmol/L (3.6-5.1)		
Chloride		103 mmol/L (101-111)		
Carbon Dioxide		24 mmol/L (22-32)		
Anion Gap		13.0 H (3.0-11.0)		
BUN		60 H mg/dL (8-20)		
Creatinine		4.1 H mg/dL (0.40-1.00)		
Est GFR (African Amer)		16 L ml/min		

Patient: GUTIERREZ,CYNTHIA
Adm Phys: Kang,Hyun
MRN#: SM02706496

Santa Rosa Memorial Hosp.
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		(>60)		
Est GFR (Non-Af Amer)		13 L ml/min (>60)		
Glucose		210 H mg/dL (65-99)		
Lactic Acid		6.5 *H mmol/L (0.5-2.2)		
Calcium		9.8 mg/dL (8.9-10.3)		
Total Bilirubin		0.6 mg/dL (0.3-1.2)		
AST		42 H IU/L (15-41)		
ALT		94 H IU/L (14-54)		
Alkaline Phosphatase		266 H IU/L (32-91)		
Rapid CK-MB (CK-2)		6.4 H ng/mL (0.6-6.3)		
Rapid Troponin I		< 0.05 ng/mL (<0.05)		
Rap B-Natriuretic Pept		> 5000 *H pg/mL (0-100)		
Total Protein		6.5 gm/dL (6.1-7.9)		
Albumin		2.9 L g/dL (3.5-4.8)		
Globulin		3.6 H gm/dL (2.3-3.5)		
ABG pH			7.29 L (7.35-7.45)	
ABG pCO2			42.8 mmHg (32-45)	
ABG pO2			328.0 H mmHg (83-100)	
ABG pO2 at Pt Temp			328 H mmHG (83-100)	
ABG HCO3			20 L mmol/L (22-26)	
ABG O2 Saturation			100.0 H % (95-99)	
ABG Base Excess			-5.7 L (-2 to +2)	

Medical Decision Making

Progress Notes

Progress Note :
Date: Feb 25, 2015
Time: 07:45
Note
Dr. Kang (ICU) at bedside, he will admit pt

Patient: GUTIERREZ,CYNTHIA
Adm Phys: Kang,Hyun
MRN#: SM02706496

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Medical decision making/Course

Course

This 33-year-old dialysis patient is extremely well known to us in the emergency department for numerous visits with nausea vomiting gastroparesis and also with a history of her multiple complications of diabetes was seen with nausea and vomiting last night. She was in good shape and the vomiting was brought under control and she was discharged as some many times previously. Her potassium was noted to be 4.9 in the department. She was discharged to the lobby and was apparently sitting there when she collapsed to the floor a code was called and our staff responded to the lobby to bring the patient back she's placed on a gurney and CPR started is no palpable pulses are detected she is placed in a critical care room him putting her on the gurney into the critical care room. CPR was continued she's intubated while the nurses are getting her hooked up to the monitors. On the cardiac monitor we see a narrow complex relatively bradycardic rhythm regular at perhaps 30. Given the critical nature of her dialysis port is accessed and her drugs are given via that route she's given calcium and bicarbonate based on the possibility of acute hyperkalemia. Is followed with epinephrine. On her initial ultrasound I can see valve motion within the heart but no significant wall motion. Following the epinephrine her heart rate speeds up and her contractility increases her blood pressure returns stopped and ultimately her heart rate is 150 slowly this drops back down to about 120. Her examination she is unresponsive she has the appearance of diabetes and renal failure, no pulses and agonal respiratory efforts. Dr.

Kang the intensivist is contacted and he comes down to see the patient and will admit her to the intensive care unit. The nephrologist are contacted.

Procedures

Intubation

Time of Intubation: 07:35
Reason for Intubation:
arrest
Assessed for difficult airway: Yes
Intubation Method: orotracheal
Tube size: 8.0
Medications: : - crash intubation
Tube placement confirmation: condensation in tube, equal chest rise, visualized going through cords
Intubation complications: none
Post intubation xray: position adjusted

Critical Care

Critical care time: 30-74 mins excluding procedures
Critical care time

This critical care time did not overlap with any other physicians or include procedures. During this critical care time, the patient was at high risk of life threatening or organ threatening decompensation.

Disposition

Latest vital signs

Vital Signs

	2/25/15 08:45
Temp	97.7
Pulse	88
Resp	14
B/P	126/63
Pulse Ox	100
O2 Delivery	Ventilator

Patient: GUTIERREZ,CYNTHIA
Adm Phys: Kang,Hyun
MRN#: SM02706496

000262

SRMH(2) 21014

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FiO2	40

Impression:
Primary Impression: Cardiopulmonary arrest
Additional Impression: ESRD (end stage renal disease) on dialysis
Condition: Critical
Disposition: Admit Acute Inpt This Fac
Admit to: ICU
Admitting provider: Dr. Kang

Attestation

Documentation prepared by Arnold, Christina M , acting as medical scribe for and in the presence of Dr. Lauterbach 2/25/15 08:08

All medical record entries made by the scribe were at my direction and in my presence. I have reviewed the chart and agree that the record accurately reflects my personal performance of the history, physical exam, medical decision making, and the emergency department course for this patient. I have also personally reviewed and agree with the discharge instructions and disposition.

EMR and Dragon Attestation - this medical document was created using an electronic medical record system with Dragon computerized dictation system. Although this document has been carefully reviewed, there may still be some phonetic and typographical errors. These errors are purely typographical, due to imperfections of the software programs, and do not reflect any compromise in the patient's medical care.

Lauterbach,Stewart A — Feb 25, 2015 07:42
Arnold,Christina M SCRIBE — Feb 25, 2015 08:09

This is not considered FINAL until Signed by a Physician

Authenticated By:
<Electronically signed by Stewart A Lauterbach MD> 02/26/15 0938

Stewart A Lauterbach

cc:

Patient: GUTIERREZ,CYNTHIA
Adm Phys: Kang,Hyun
MRN#: SM02706496

SRMH(2) 21015

000263

Santa Rosa Memorial

:ient: GUTIERREZ,CYNTHIA
--e/Sex 33/F **DOB** 07/31/1981
Status ADM IN (NSMW268-01)
ED.Phys Lauterbach,Stewart A

02/25/15 0754 **Room** S25
Height 5 ft 2 in
Weight 58.2 kg

Acct# SV0083448563
Unit# SM02706496
Dep'd 02/25/15 0837
PC.Phys Southwest Community,Health Cli

PATIENT DEMOGRAPHICS

3492 STONY POINT RD
SANTA ROSA, CA 95407
714-673-1287
Insurance: Partnership Managed Medicaid
Next of Kin: HUERTA,JOSE
Relation: Husband
Phone: 714-673-1287

PCP: Southwest Community,Health Cli
Family Doctor:
Referring:

GENERAL DATA

ED Physician: Lauterbach,Stewart A, ACT
Practitioner:
Nurse: Bishop,Deborah, RN

Arrival Date/Time: 02/25/15 - 0726
Triage Date/Time: 02/25/15 - 0726
Date of Birth: 07/31/1981

Stated Complaint: INDIA,A472/CARDIAC ARREST,RENAL FAILURE
Chief Complaint: Arrest
Priority: 1

HISTORY OF PRESENT ILLNESS

02/25/15 0726 Bishop,Deborah
History Of Present Illness CODE BLUE FROM WR, SEE PAPER CHART

ALLERGIES

Unable to Obtain

HEIGHT & WEIGHT

02/25/15 0835 Aquila,Deborah M
Weight (Calculated Kilogram) 58.2
Weight Source Bed Scale

02/25/15 0840 Aquila,Deborah M
Height (Feet) 5
Height (Inches) 2
Height Measurement Method Estimated
Weight (Calculated Kilogram) 58.2
Weight Source Bed Scale

PAST MEDICAL HISTORY

02/25/15 0812 Arnold,Christina M
Dialysis Y
Renal Failure Y
Diabetes Mellitus Type 2 Y
Hypothyroidism Y

Santa Rosa Memorial

Client: GUTIERREZ,CYNTHIA 02/25/15 0754 Room S25 Acct# SV0083448563
Age/Sex 33/F DOB 07/31/1981 Height 5 ft 2 in Unit# SM02706496
Status ADM IN (NSMW268-01) Weight 58.2 kg Dep'd 02/25/15 0837
ED.Phys Lauterbach,Stewart A PC.Phys Southwest Community,Health Cli

ASSESSMENTS

02/25/15 0726 ED Adult Triage Assessment — *Bishop,Deborah, RN*

History Of Present Illness CODE BLUE FROM WR, SEE PAPER CHART
Traveled Or Hospitalized Outside USA In Last 30 Days No
Is Patient Female? Y
Currently Pregnant? N
Currently Breastfeeding? N
Priority 1 Resuscitation

02/25/15 0837 ED Adult Disposition Assessmnt — *Bishop,Deborah, RN*

Organ Dysfunction Criteria Present (Acute Only, Not Chronic) Altered LOC/Confusion
Admit Report Given To RN NANCY
Time Report Given 0835
Admission Destination ICU 268
Admission Mode Stretcher
Equipment Used To Transfer Patient IV, Cardiac Monitor, Oxygen, Other
Patient Accompanied By RN, RT
Patient Belongings Sent Y

02/25/15 0926 ED Patient Belongings — *Bishop,Deborah, RN*

Does Patient Have Belongings/Valuables Y
Performed On Admission
Unit Transferred From ED
Unit Transferred To ICU RM 268
Dentures None
Partial(s) None
Contacts Len(s) None
Glasses None
Hearing Aids None
Clothing Slippers, Pants
Other Clothing SHIRTS AND BRA CUT OFF
Home Medication(s) None
Other Valuable(s) Cell Phone

MEDICATIONS

Medication
Sch Date-Time Ordered Dose Admin Dose
Doc Date-Time Given - Reason Site User
Pantoprazole Inj 80 MG in Sodium Chloride 0.9% 100 ML (Protonix Inj 80 MG in Normal Saline 1

Acknowledgements
Ack Date-Time User
02/25/15-0922 Sweet,Nancy L

Santa Rosa Memorial

:ient: GUTIERREZ,CYNTHIA
--ge/Sex 33/F **DOB** 07/31/1981
Status ADM IN (NSMW268-01)
ED.Phys Lauterbach,Stewart A

02/25/15 0754 **Room** S25
Height 5 ft 2 in
Weight 58.2 kg

Acct# SV0083448563
Unit# SM02706496
Dep'd 02/25/15 0837
PC.Phys Southwest Community,Health Cli

LAB RESULTS

Test	Date	Time	Result		Reference	Units
WBC	2/25/15	1800	PENDING		(3.5-11.0)	10^3/uL
WBC	2/25/15	1200	PENDING		(3.5-11.0)	10^3/uL
WBC	2/25/15	0747	12.2	H	(3.5-11.0)	10^3/uL
RBC	2/25/15	1800	PENDING		(3.50-5.50)	10^6/uL
RBC	2/25/15	1200	PENDING		(3.50-5.50)	10^6/uL
RBC	2/25/15	0747	2.78	L	(3.50-5.50)	10^6/uL
HGB	2/25/15	1800	PENDING		(12.0-15.0)	g/dL
HGB	2/25/15	1200	PENDING		(12.0-15.0)	g/dL
HGB	2/25/15	0747	8.1	L	(12.0-15.0)	g/dL
HCT	2/25/15	1800	PENDING		(36.0-45.0)	%
HCT	2/25/15	1200	PENDING		(36.0-45.0)	%
HCT	2/25/15	0747	26.0	L	(36.0-45.0)	%
MCV	2/25/15	1800	PENDING		(79-95)	fL
MCV	2/25/15	1200	PENDING		(79-95)	fL
MCV	2/25/15	0747	93		(79-95)	fL
MCH	2/25/15	1800	PENDING		(26.0-33.0)	pg
MCH	2/25/15	1200	PENDING		(26.0-33.0)	pg
MCH	2/25/15	0747	29.2		(26.0-33.0)	pg
'C	2/25/15	1800	PENDING		(32.0-36.0)	g/dL
.HC	2/25/15	1200	PENDING		(32.0-36.0)	g/dL
MCHC	2/25/15	0747	31.2	L	(32.0-36.0)	g/dL
RDW	2/25/15	1800	PENDING		(11.0-14.0)	%
RDW	2/25/15	1200	PENDING		(11.0-14.0)	%
RDW	2/25/15	0747	16.6	H	(11.0-14.0)	%
PLT	2/25/15	1800	PENDING		(120-400)	THD/uL
PLT	2/25/15	1200	PENDING		(120-400)	THD/uL
PLT	2/25/15	0747	163		(120-400)	THD/uL
MPV	2/25/15	1800	PENDING		(7.4-10.4)	fL
MPV	2/25/15	1200	PENDING		(7.4-10.4)	fL
MPV	2/25/15	0747	10.1		(7.4-10.4)	fL
Neutrophils %	2/25/15	1800	PENDING		(34-64)	%
Neutrophils %	2/25/15	1200	PENDING		(34-64)	%
Neutrophils %	2/25/15	0747	52.9		(34-64)	%
Lymphocytes %	2/25/15	1800	PENDING		(19-48)	%
Lymphocytes %	2/25/15	1200	PENDING		(19-48)	%
Lymphocytes %	2/25/15	0747	36.3		(19-48)	%
Monocytes %	2/25/15	0747	7.0		(3-9)	
Eosinophils %	2/25/15	0747	2.2		(0-7)	%
Basophils %	2/25/15	0747	1.6		(0-2)	%
Neutrophils #	2/25/15	1800	PENDING		(2.5-5.6)	THD/uL
Neutrophils #	2/25/15	1200	PENDING		(2.5-5.6)	THD/uL
Neutrophils #	2/25/15	0747	6.5	H	(2.5-5.6)	THD/uL
Lymphocytes #	2/25/15	1800	PENDING		(0.8-3.5)	10^3/uL
Lymphocytes #	2/25/15	1200	PENDING		(0.8-3.5)	10^3/uL

Santa Rosa Memorial

Patient: GUTIERREZ,CYNTHIA
Age/Sex 33/F **DOB** 07/31/1981
Status ADM IN (NSMW268-01)
ED.Phys Lauterbach,Stewart A

02/25/15 0754 **Room** S25
Height 5 ft 2 in
Weight 58.2 kg

Acct# SV0083448563
Unit# SM02706496
Dep'd 02/25/15 0837
PC.Phys Southwest Community,Health Cli

Test	Date	Time	Result		Reference	Units
Lymphocytes #	2/25/15	0747	4.4	H	(0.8-3.5)	10^3/uL
Monocytes #	2/25/15	0747	0.9		(0.2-1.0)	THD/uL
Eosinophils #	2/25/15	0747	0.3		(0-0.5)	THD/uL
Basophils #	2/25/15	0747	0.2	H	(0-0.1)	THD/uL
Slide Review	2/25/15	0747	<10% BANDS			
Man Diff	2/25/15	0747	(A)			

(A) Not Indicated

Anisocytosis	2/25/15	0747	2+			
PTT	2/25/15	0747	25.8(B)		(23.0-36.3)	SEC

(B) Anti-Xa activity is the preferred alternate method to monitor heparin therapy.

As of Sept 2013, the following tests are now orderable:
HEPARIN ANTI-Xa ACT,LOW MOLEC
HEPARIN ANTI-Xa ACT,UNFRACTION

PT	2/25/15	0747	14.5	(11.9-14.8)	Sec.
	2/25/15	0747	1.10	(0.6-1.4)	
Urine Color	2/25/15	0731	PENDING	(Yellow)	
Ur Clarity	2/25/15	0731	PENDING	(Clear)	
Ur Spec Gravity	2/25/15	0731	PENDING	(1.005-1.030)	
Urine pH	2/25/15	0731	PENDING	(5.0-8.0)	
Urine Protein	2/25/15	0731	PENDING	(Negative)	mg/dL
Urine Glucose	2/25/15	0731	PENDING	(Negative)	mg/dL
Urine Ketones	2/25/15	0731	PENDING	(Negative)	mg/dL
Urine Bilirubin	2/25/15	0731	PENDING	(Negative)	
Urine Blood	2/25/15	0731	PENDING	(Negative)	
Urine Nitrite	2/25/15	0731	PENDING	(Negative)	
Ur Urobilinogen	2/25/15	0731	PENDING	(0.2-1.0)	mg/dL
Ur Leu Est	2/25/15	0731	PENDING	(Negative)	
UA Sp Desc	2/25/15	0731	PENDING		
Glucose	2/25/15	1800	PENDING	(65-99)	mg/dL
Glucose	2/25/15	1200	PENDING	(65-99)	mg/dL
Glucose	2/25/15	0747	PENDING	(70-130)	mg/dL
Na	2/25/15	1800	PENDING	(136-144)	mmol/L
Na	2/25/15	1200	PENDING	(136-144)	mmol/L
Na	2/25/15	0747	140	(136-144)	mmol/L
K	2/25/15	1800	PENDING	(3.6-5.1)	mmol/L
K	2/25/15	1200	PENDING	(3.6-5.1)	mmol/L
K	2/25/15	0747	4.3	(3.6-5.1)	mmol/L
Cl	2/25/15	1800	PENDING	(101-111)	mmol/L
Cl	2/25/15	1200	PENDING	(101-111)	mmol/L
Cl	2/25/15	0747	103	(101-111)	mmol/L

Santa Rosa Memorial

Patient: GUTIERREZ,CYNTHIA
Age/Sex 33/F **DOB** 07/31/1981
Status ADM IN (NSMW268-01)
ED.Phys Lauterbach,Stewart A

02/25/15 0754 **Room** S25
Height 5 ft 2 in
Weight 58.2 kg

Acct# SV0083448563
Unit# SM02706496
Dep'd 02/25/15 0837
PC.Phys Southwest Community,Health Cli

Test	Date	Time	Result		Reference	Units
CO2	2/25/15	1800	PENDING		(22-32)	mmol/L
CO2	2/25/15	1200	PENDING		(22-32)	mmol/L
CO2	2/25/15	0747	24		(22-32)	mmol/L
Anion Gap	2/25/15	1800	PENDING		(3.0-11.0)	
Anion Gap	2/25/15	1200	PENDING		(3.0-11.0)	
Anion Gap	2/25/15	0747	13.0	H	(3.0-11.0)	
BUN	2/25/15	1800	PENDING		(8-20)	mg/dL
BUN	2/25/15	1200	PENDING		(8-20)	mg/dL
BUN	2/25/15	0747	PENDING		(8-26)	mg/dL
Creatinine	2/25/15	1800	PENDING		(0.40-1.00)	mg/dL
Creatinine	2/25/15	1200	PENDING		(0.40-1.00)	mg/dL
Creatinine	2/25/15	0747	PENDING		(0.44-1.00)	mg/dL
Calcium	2/25/15	1800	PENDING		(8.9-10.3)	mg/dL
Calcium	2/25/15	1200	PENDING		(8.9-10.3)	mg/dL
Calcium	2/25/15	0747	9.8		(8.9-10.3)	mg/dL
TP	2/25/15	0747	PENDING		(6.5-8.1)	gm/dL
Alb	2/25/15	0747	PENDING		(3.5-4.8)	g/dL
T Bili	2/25/15	0747	PENDING		(0.3-1.2)	mg/dL
AST	2/25/15	0747	PENDING		(15-41)	IU/L
ALT	2/25/15	0747	PENDING		(5-32)	IU/L
Phos	2/25/15	0747	PENDING		(32-91)	IU/L
Globulin	2/25/15	0747	PENDING		(2.6-3.1)	gm/dL
GFR Non-Af Am	2/25/15	1800	PENDING		(>60)	ml/min
GFR Non-Af Am	2/25/15	1200	PENDING		(>60)	ml/min
GFR Non-Af Am	2/25/15	0747	PENDING		(>60)	ml/min
Lactic Acid	2/25/15	0747	PENDING		(0.5-2.2)	mmol/L
CKMB Rapid	2/25/15	0747	6.4(C)	H	(0.6-6.3)	ng/mL

(C) ****** CRITICAL VALUE ******
CALLED AND READ BACK BY:
AUTOINS on02/25/15(0820),TO []
NURSE_____NOTIFIED DR._____DATE:_____TIME:_____
(Completed on hard copy only)
IF DR. NOT NOTIFIED REASON:_____

Santa Rosa Memorial

Patient: GUTIERREZ,CYNTHIA 02/25/15 0754 **Room** S25 **Acct#** SV0083448563
Age/Sex 33/F **DOB** 07/31/1981 **Height** 5 ft 2 in **Unit#** SM02706496
Status ADM IN (NSMW268-01) **Weight** 58.2 kg **Dep'd** 02/25/15 0837
ED.Phys Lauterbach,Stewart A **PC.Phys** Southwest Community,Health Cli

Test	Date	Time	Result		Reference	Units
Rap Trop I	2/25/15	0747	< 0.05(D)		(<0.05)	ng/mL
BNPT	2/25/15	0747	> 5000(D)	*H	(0-100)	pg/mL

(D) POSITIVE
****** CRITICAL RESULT******
CALLED AND BROADCAST TO DEB, RN, ER AT 0825,02/25/15 BY LAB CATHEYLI01.
NURSE_____NOTIFIED DR._____DATE:_____TIME:_____
(Completed on hard copy only)
IF DR. NOT NOTIFIED REASON:_____

BNP LEVEL ADDITIONAL INTERPRETATIONS
0-100 PG/ML Highly unlikely that patient's symptoms result from systolic or diastolic dysfuntion.
101-200 PG/ML BNP greater than 100 pg/ml is considered positive and indicative of heart failure. LV Dysfunction with no acute CHF=141 (+/-31). Severe Right Heart Failure, Pulm HTN, or large Pulm Embolus may equal 100-200 pg/ml.
201-479 PG/ML Almost always Left Heart Failure. AMI with CHF may have elevated levels; Positive BNP should not be viewed as excluding a diagnosis of AMI.
Equal to or greater than 480 PG/ML
Patients who present with dyspnea and BNP level equal to or greater than 480 have a nearly 30-fold increased risk for a cardiac event in the next 6 months.

Bedside Glucose	2/25/15	0848	101	H	(65-99)	mg/dL
Bedside Glucose	2/25/15	0741	200	H	(65-99)	mg/dL
ABG pH	2/25/15	0750	7.29	L	(7.35-7.45)	
ABG PCO2	2/25/15	0750	42.8		(32-45)	mmHg
ABG pO2	2/25/15	0750	328.0	H	(83-100)	mmHg
Art pO2 Corr	2/25/15	0750	328	H	(83-100)	mmHG
ABG HCO3	2/25/15	0750	20	L	(22-26)	mmol/L
ABG Base Excess	2/25/15	0750	-5.7	L	(-2 to +2)	
ABG O2 Sat	2/25/15	0750	100.0	H	(95-99)	%

ORDERS

Ordered	Procedure Name	Ordering Provider	E-Signed
02/25/15 0733	CBC w/ Differential	Lauterbach,Stewart A, ACT	No
02/25/15 0733	CMP Comp Metabolic Panel CMP	Lauterbach,Stewart A, ACT	No
02/25/15 0733	Cardiac Panel Baseline	Lauterbach,Stewart A, ACT	No
02/25/15 0733	PT Prothrombin Time w INR PT	Lauterbach,Stewart A, ACT	No
02/25/15 0733	PTT Act Partial Thromboplast	Lauterbach,Stewart A, ACT	No
02/25/15 0733	Lactic Acid Level LA	Lauterbach,Stewart A, ACT	No

Santa Rosa Memorial

:ient: GUTIERREZ,CYNTHIA 02/25/15 0754 **Room** S25 **Acct#** SV0083448563
_ge/Sex 33/F **DOB** 07/31/1981 **Height** 5 ft 2 in **Unit#** SM02706496
Status ADM IN (NSMW268-01) **Weight** 58.2 kg **Dep'd** 02/25/15 0837
ED.Phys Lauterbach,Stewart A **PC.Phys** Southwest Community,Health Cli

02/25/15 0733	XR Chest 1V Portable	Lauterbach,Stewart A, ACT	No
02/25/15 0733	EKG/ ECG	Lauterbach,Stewart A, ACT	No
02/25/15 0733	ZTAG-E-ED-Code-Critical	Lauterbach,Stewart A, ACT	N/A
02/25/15 0733	Urinalysis (UA)	Lauterbach,Stewart A, ACT	No
02/25/15 0733	Morphology	Lauterbach,Stewart A, ACT	No
02/25/15 0746	CMP Comp Metabolic Panel CMP	Lauterbach,Stewart A, ACT	Yes
02/25/15 0746	CBC w/ Differential	Lauterbach,Stewart A, ACT	Yes
02/25/15 0746	Lactic Acid Level LA	Lauterbach,Stewart A, ACT	Yes
02/25/15 0746	PT Prothrombin Time w INR PT	Lauterbach,Stewart A, ACT	Yes
02/25/15 0747	Arterial Blood Gas ABG	Lauterbach,Stewart A, ACT	No
02/25/15 0751	CT Head Brain wo IV	Lauterbach,Stewart A, ACT	Yes
02/25/15 0808	Glucose Bedside	Lauterbach,Stewart A, ACT	N/A
02/25/15 0811	Admit as Inpatient	Kang,Hyun	Yes
02/25/15 0811	Code/ Resuscitation Status	Kang,Hyun	Yes
02/25/15 0811	* Bedrest	Kang,Hyun	Yes
02/25/15 0811	RC Vent Adult/PED	Kang,Hyun	Yes
02/25/15 0811	* Elevate Head Of Bed HOB	Kang,Hyun	Yes
02/25/15 0811	CBC w/ Differential	Kang,Hyun	Yes
02/25/15 0811	CBC w/ Differential	Kang,Hyun	Yes
02/25/15 0811	CBC w/ Differential	Kang,Hyun	Yes
02/25/15 0811	CBC w/ Differential	Kang,Hyun	Yes
02/25/15 0811	CBC w/ Differential	Kang,Hyun	Yes
02/25/15 0811	CBC w/ Differential	Kang,Hyun	Yes
'25/15 0811	BMP Basic Metabolic Panel BMP	Kang,Hyun	Yes
,25/15 0811	BMP Basic Metabolic Panel BMP	Kang,Hyun	Yes
02/25/15 0811	BMP Basic Metabolic Panel BMP	Kang,Hyun	Yes
02/25/15 0811	BMP Basic Metabolic Panel BMP	Kang,Hyun	Yes
02/25/15 0811	BMP Basic Metabolic Panel BMP	Kang,Hyun	Yes
02/25/15 0811	BMP Basic Metabolic Panel BMP	Kang,Hyun	Yes
02/25/15 0811	ZTAG-N-ICU-Admission	Kang,Hyun	Yes
02/25/15 0811	* NPO Now	Kang,Hyun	Yes
02/25/15 0811	* Daily Weight kg	Kang,Hyun	Yes
02/25/15 0811	XR Chest 1V Portable	Kang,Hyun	Yes
02/25/15 0811	VTE Risk Assessment	Kang,Hyun	Yes
02/25/15 0811	ZTAG-E-VTE-Prophylaxis	Kang,Hyun	Yes
02/25/15 0811	Propofol 10 mg/mL Inj (Dipr...	Kang,Hyun	Yes
02/25/15 0811	Sodium Chloride 0.9... w/Pa...	Kang,Hyun	Yes
02/25/15 0811	NPO Diet	Kang,Hyun	Yes
02/25/15 0813	ED Request to Admit	Lauterbach,Stewart A, ACT	Yes
02/25/15 0850	Glucose Bedside	Lauterbach,Stewart A, ACT	N/A
02/25/15 0855	MRSA Culture Admission	Kang,Hyun	No

DEPARTURE

Primary Impression:
Cardiopulmonary arrest
Secondary Impressions:
ESRD (end stage renal disease) on dialysis
Disposition: Admit Acute Hosp This Fac **Departure Date/Time:** 02/25/15 - 0837
Comment:

GUTIERREZ,CYNTHIA **Acct#** SV0083448563 **Unit#** SM02706496
/Sex 33/F **DOB** 07/31/1981
atus ADM IN

Santa Rosa Memorial

ient: GUTIERREZ,CYNTHIA 02/25/15 0754 **Room** S25 **Acct#** SV0083448563
Age/Sex 33/F **DOB** 07/31/1981 **Height** 5 ft 2 in **Unit#** SM02706496
Status ADM IN (NSMW268-01) **Weight** 58.2 kg **Dep'd** 02/25/15 0837
ED.Phys Lauterbach,Stewart A **PC.Phys** Southwest Community,Health Cli

Condition: Critical

Referrals:
Southwest Community,Health Cli
751 Lombardi Ct
Santa Rosa, CA 95407
Phone: 707-547-2222 Fax: 707-547-2229

Pt Instructions:

Additional Instructions:

Care Plan:

Departure Forms:

Departure Screen :

CARE PROVIDERS

Staff History:
ED Physician:
02/25/15 0741 Lauterbach,Stewart A, ACT
Practitioner:
Nurse:
02/25/15 0910 Bishop,Deborah, RN

Santa Rosa Memorial
1165 Montgomery Drive
Santa Rosa, CA 95405

Imaging Services

Patient Name: GUTIERREZ,CYNTHIA
Account #: SV0083448385
Unit #: SM02706496

DOB: 07/31/1981
Age/Sex: 33/F
Location: NSMED

Admitting Dr:
Ordering Dr: Brandwene, Elliott L MD
Primary Dr: Southwest Community,Health Cli
Exam Performed: XR Chest 1V Portable
Date of Service: 02/25/15
Req #: 15-0046705
Accession #: 785411.001NSM

EXAMINATION: PORTABLE CHEST X-RAY: 02/25/2015

CLINICAL HISTORY: Congestion; cough.

COMPARISON: February 12.

FINDINGS: Portable view of the chest obtained. Stable right IJ large bore dual lumen central line. Heart is enlarged but stable. No pneumothorax. There is prominence of the pulmonary vascularity as well as bilateral interstitial infiltrates. No significant effusion on portable exam.

IMPRESSION:
Stable cardiomegaly. There is pulmonary vascular congestion and interstitial infiltrates. Findings suggest fluid overload with congestive failure.

Findings noted by ER physician.

Job #:
76171602
<Electronically signed by Shawn P Daly MD> 02/25/15 1440
Signed

Shawn P Daly MD

Report #: 0225-0120
Dictated Date/Time: 02/25/15 0822
Transcribed Date/Time: 02/25/15 0927
Transcriptionist: WEISSDI01

EXHIBIT D

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

- - -

CYNTHIA GUTIERREZ, JOSE HUERTA, SMH, RH and AH,

Plaintiffs,

vs.

No. 4:16-cv-02645-DMR

SANTA ROSA MEMORIAL HOSPITAL, ST. JOSEPH HEALTH and DOES 1-50, inclusive,

Defendants.

DEPOSITION OF

STEWART LAUTERBACH, M.D.

SANTA ROSA, CALIFORNIA

MARCH 22, 2017

ATKINSON-BAKER, INC.
COURT REPORTERS
(800) 288-3376
www.depo.com

REPORTED BY: MICHELLE D. BARBANTE, CSR NO. 12601

FILE NO.: AB02108

A. No.
Q. Do you know where she's at?
A. I don't.
Q. Okay. Do you know when she left?
A. About a year ago.
Q. And your preparation of this record, is it similar to your preparation of the August 10, 2014, record in that the scribe would have inputted anything that did not automatically populate up to the medical decision making section?
A. That's correct.
Q. All right. Okay. How did you come to see or treat Ms. Gutierrez on February 25, 2015?
A. It was the beginning of the shift. I had come to work, and Dr. Brandwene had worked over the night, and as is our custom, he went over the patients in the department. This patient had been discharged and was not brought to my attention because she was no longer in the department.
Q. Can I stop you right there? What time does that occur? What was the shift change time?
A. At that point, I'm pretty sure we were doing 7:00 a.m.
Q. And would you actually do the shift at 7:00 a.m. or did you have to be there at 6:45 to start the shift

change? How did that work?
A. Technically, we start at 7:00.
Q. Okay.
A. That depends on the habit of the person coming in.
Q. What was your custom and practice for coming in?
A. I'm always there a couple of minutes early.
Q. Okay. And is the first thing you do -- strike that.
Do you clock in, sign in, anything like that?
A. Just log in to the computer.
Q. Okay. And then after you log in, is that -- strike that.
Is that the first thing you do is log in to the computer?
A. Mm-hm.
Q. Is that yes?
A. Yes.
Q. Okay. And then is the next thing you do, go find the doctor who's working the shift before and get a report?
A. Not necessarily.
Q. Okay.
A. There's usually a pretty quick exchange between the two docs, and something to the extent of, "Is there

anything I need to know?" And then usually we'll dive into patients and start seeing new patients, because the existing doc will hang around for a while to try to wrap up their loose ends. When they're ready to go, they'll corner us and go over the patients in the department.
Q. And customarily when does that occur?
A. Anywhere from 15 minutes to two hours after --
Q. Okay.
A. -- shift ends.
Q. Okay. On this particular day, February 25, 2015, do you have a recollection of getting the shift report prior to seeing Ms. Gutierrez?
A. I -- I don't have recollection of it being before I saw her, but I'm sure I had -- it had been done, because he had left.
Q. Okay.
A. And it wouldn't happen -- he wouldn't leave without it.
Q. Right. Okay. So you have a recollection of Dr. Brandwene being gone by the time you saw Ms. Gutierrez?
A. Correct.
Q. All right. And because she was not a patient there anymore, you're confident you did not receive any type of report about her in that exchange?

A. I -- I did not.
Q. Okay. All right. Okay. So you -- you came in, you clocked in. At some point prior to seeing Ms. Gutierrez, you received a report from Dr. Brandwene and he had left. How did you get involved in Ms. Gutierrez's care?
A. I don't remember the exact details, but I know that the patient had collapsed in the lobby or was found unresponsive. Our crew was sent out to bring her back -- and that would usually consist of the triage nurse and one or two techs and maybe another nurse or two -- and brought her immediately to one of our critical care rooms.
Q. Did you see the patient while she was still in the waiting room, or did you see her when she was brought into the critical care room?
A. My recollection is that I saw her as she was wheeled down the hall to the critical care room and traveled down there with her.
Q. And was this a -- some sort of code that was called at the hospital?
A. We don't call codes overhead for the emergency department. After all, we are the code center. We have all our resources. We don't look for outside resources. With a few exceptions, and this would not have been one of those exceptions.

A. Well, initially, we'll try it with a bag-valve mask. The techs or the respiratory therapist will grab a bag-valve mask and start bagging somebody. And then we will immediately turn to intubating a patient to get a secure airway.

And you must understand that at this point we have a team of about six people there, and everybody has assignments and they position themselves in the appropriate places. So our -- our responsibility in the beginning, as the head of the bed, to control the airway. At the same time, we'll have nurses putting monitor leads on. We'll have other nursing getting IVs in. We'll have -- or techs getting IVs in. Respiratory therapist or a tech will be bagging the patient. So there's a lot simultaneously going on.

Q. And that kind of goes back to my earlier question where I asked what was your role, and that's what I was trying to figure out. I understand -- so there is a team of individuals, six people possibly there, doing things. What is it that you personally are doing?

MR. NELSON: He said he's at the head of the bed.

BY MR. SCHOEL:

Q. Head of the bed. All right. Fine.

A. But I'm the captain of the ship, so I'm

dictating or ordering, you know: Let's -- let's get this med on board, let's do this. And I think in this dictation in the back, I talked about giving calcium and bicarb right away.

Q. Okay.

A. I'd have to go back and review that, but I believe we did, because the most common cause of cardiac arrest -- sorry, one of the most common causes of cardiac arrest in a dialysis patient is a hyperkalemia, and so the first thing you do --

Q. Hyper or hypo?

A. Kalemia.

Q. But hyper or hypo?

A. Hyperkalemia. And so the initial thing that we would do is start treating the hyperkalemia, even if you don't know what the potassium is.

Q. Okay.

MR. NELSON: So are you interested in what he did with this patient?

MR. SCHOEL: Yes.

MR. NELSON: So with this patient, he's asking what you recall and/or what's reflected that you did.

BY MR. SCHOEL:

Q. And what I'm getting at, I understand you're the captain of the ship, and that's what I'm getting to the specifics. I assume you're not just standing at the head of the bed. You're either -- like you told me already, you're making -- you're giving orders. Are you physically doing anything? Are you helping to establish airway?

A. Oh, yeah.

Q. That's what I'm asking.

A. I intubated this patient.

Q. Okay. And that's where I'm kind of going. But prior to intubating the patient, were you doing anything else? I mean, you're there at the head of the bed.

A. Well, I mean, the initial thing is gathering information: What happened?

Q. Okay. All right.

A. What do we know about this patient? What's their past medical history? What kind of drugs are they on?

Q. Okay.

A. It's --

Q. So you gather information?

A. As much as we can in as brief a time as possible.

Q. Okay.

A. And then get an airway established.

Q. Okay.

A. And then once the airway's established, turn

attention to blood pressure, blood flow, heart rate, monitor rhythm, and --

Q. And how did you establish the airway in this patient? I know I'm asking some basic questions, but I want you to take me step by step.

A. Okay.

Q. What you did and what you would normally do based on your custom and practice. So how did you establish an airway in this case?

A. In this case -- in any case like this where a patient's unresponsive, we would intubate the patient.

Q. Okay.

A. So the first thing that I would do is focus on preparing for intubation, and that is gathering the appropriate equipment. Usually we have a respiratory therapist there with us. And in this case, Dan Bradford was the respiratory therapist. In my medical decision making, I note his name. And --

Q. And is the --

A. In the addendum I did.

MR. NELSON: So you gathered the equipment.

THE WITNESS: Yeah.

MR. NELSON: What next did you do here?

THE WITNESS: And then take the laryngoscope, look inside, look in the patient's mouth, look for the

anatomic structures we need to identify, take the tube and put it in the trachea.
BY MR. SCHOEL:
Q. And is that you physically doing it or is the respiratory therapist doing it?
A. No, I'm doing it.
Q. Okay. And I know we can just kind of skip to it, I know it's in your addendum, but I note in your addendum, if I understood it correctly, that there was a large piece of food was aspirated from the ET tube; is that correct?
A. So after the tube was in, and then Dan would have taken and secured the tube and suctioned it. And when he suctioned it, he pulled out a piece of food, and it was fairly large. And that would have been within a couple of minutes of the time we intubated the patient.
Q. When you inspected the airway before placing the tube, could you see the food?
A. I did not see it.
Q. When you arrived to the patient's bed, as she's being wheeled down the hallway, you said they were already bagging the patient?
MR. NELSON: Bag-valve would be used.
THE WITNESS: Bag-valve mask. It's my recollection, yes.

BY MR. SCHOEL:
Q. From your perception, was it being used effectively?
A. I can't answer that.
Q. You don't know one way or the other?
A. I don't know one way or the other.
Q. The large piece of food that was removed, could you identify what it was?
A. I probably could have if I cared about taking the time to do it. That's -- it doesn't matter to me what it is. What matters is that we get the airway open.
Q. Is the food just discarded at that point?
A. Yeah.
MR. FLADSETH: Is that a "yes"?
THE WITNESS: Yes.
MR. FLADSETH: Thank you.
BY MR. SCHOEL:
Q. You also wrote here in your addendum that you questioned that the -- whether she could have had an aspiration leading to hypoxia and the collapse. Does that mean the food was block -- she was choking?
A. That would be my speculation based on my statement there.
Q. Okay. Were you able to confirm one way or the other back on February 25, 2015, or shortly thereafter,

whether that's what -- that was the cause of her collapse?
A. No.
Q. Okay. Is that unusual to have food suctioned out of the endotracheal tube?
A. It's -- it's relatively unusual, but it does happen. That's the way Henry Heimlich developed the Heimlich maneuver.
Q. Explain to me, how far down does the endotracheal tube go?
A. Ideally, about three centimeters above the carina.
Q. So this is not food being suctioned out of the stomach?
A. No. No, no. It's coming out of the respiratory tree somewhere.
Q. And again, can you help me understand. Explain the anatomy to me again. So it goes down about three centimeters where?
A. Above the carina.
Q. And where is that?
A. The carina is where the main stem bronchus splits into the right and left bronchi -- or the trachea and splits into the right and left main stem bronchus.
Q. So it's still in the trachea?
A. Yes.

Q. So presumably the food was in the trachea?
A. Presumably the food was in the trachea somewhere.
Q. Okay. Now the "Medical Decision Making" portion of this chart you typed in yourself or dictated in using Dragon, correct?
A. Using Dragon, correct.
Q. The addendum, is that something you also dictated yourself?
A. Yes.
Q. All right. Now it looks like you signed your note after finishing, based on your custom and practice, the "Medical Decision Making" section on February 25?
A. Twenty-six.
Q. Oh, I'm sorry. You're right. I'm sorry. You signed your note on February 26th, 2015, at 9:38; is that correct?
A. That's correct.
Q. And that's when you would have written, based on your custom and practice, the "Medical Decision Making" section?
A. That's right.
MR. FLADSETH: Where did you get that time?
THE WITNESS: It's the very last line on the whole thing.

A. No.
Q. All right. Did you review any documents to prepare for today's deposition?
A. Just the emergency department record.
MR. FLADSETH: Okay. Let's mark that as Exhibit 2 please.
(Whereupon Plaintiffs' Exhibit 1 was marked for identification.)
BY MR. FLADSETH:
Q. Now, when we did your first deposition, we marked two exhibits, A and B -- actually, Mr. Schoel on behalf of the hospital took the lead in that deposition, so that's why they're A and B rather than 1 and 2, which plaintiff would use numbers.
Is that the same as one of the exhibits to --
A. I don't know --
Q. Can I just see it?
A. I don't know what A and B are, so I can't --
Q. Oh, okay. Can I see your Exhibit 2 today. Thanks.
MR. FINKEL: It look looks like Exhibit B, although there may be a page or two extra in what the doctor looked at.
MR. FLADSETH: Okay.
MR. FINKEL: You can see...

BY MR. FLADSETH:
Q. All right. So Exhibit 2 to today's deposition includes your addendum note of February 26th, 2015, correct?
A. Yes.
Q. Now, is everything below that one paragraph that is electronically signed by you at 13 -- or 11:13 hours on the 26th, is everything below that, like the bottom half of the page, does that start with what the original note was?
A. It started with the original note.
Q. Okay. So then the top half of the first page of Exhibit 2 is your addendum, and the rest of it is the original note from the 25th?
A. Well, I completed the original note on the 26th.
Q. Okay.
A. I signed it off at 9:38 in the morning.
Q. Okay. But what you added as an addendum is just the top half of the first page --
A. Correct.
Q. -- of Exhibit 2?
A. Correct.
Q. And the rest of it was there before?
A. Correct.

Q. And meaning that it was there on the 25th?
MR. SCHOEL: Objection. Misstates the document.
MR. FINKEL: Join.
MR. FLADSETH: Okay. That's why I'm trying to make sure we're on the same page here.
MR. FINKEL: He just explained he signed the original note the morning of the 26th.
MR. FLADSETH: Right.
MR. FINKEL: A few hours before signing the addendum.
BY MR. FLADSETH:
Q. Okay. But signing is one thing. When did you type it in in the first place?
A. The medical decision making I would have done it immediately before I signed it on the 26th. I usually do those the next day.
Q. Okay. So everything -- your whole note, nothing was typed in by you on the 25th; is that correct?
A. I can't answer that for sure. I certainly could have entered some of this stuff or my scribe would have entered it. But what I attempt to do and my custom is to sit down the next day and to do a medical decision-making course that explains to the other

doctors and the people who are going to take care of the patient what really happened.
Q. Okay.
A. Because the electronic record just is impossible to read.
Q. Okay. So if we start with February 25th, 2015, you were called because of the equivalent of a code blue, right? They don't call it a code blue because you're already in the ER, but you were called emergently to respond?
A. I was the physician on duty when the code happened.
Q. Okay. And then what --
A. I was the only one there so it's...
Q. Yeah. Well, I mean, how did you know to first respond to Cynthia Gutierrez was down?
A. Somebody collapsed in the lobby and our crew got sent out. And it's a small enough department. We pretty much know -- when you're the only one working, you pretty much know what's going on everywhere.
Q. Sure.
Do you actually remember like hearing somebody shout or saying, "Dr. Lauterbach, please come to the waiting room?" Or do you have any memory of that?
A. I don't have any memory of that.

Q. Okay. Now, when you -- did you actually get to the waiting room?
A. No.
Q. Where was Cynthia when you first saw her?
A. Being wheeled down the hall by the staff.
Q. Okay. And which hall was she in?
A. I don't know how to answer that question.
Q. Okay. Somewhere between --
A. The waiting room and the critical care bed.
Q. And where is the critical care bed located?
A. 23 and 24.
Q. I mean, it's in the ER?
A. Oh, yes.
Q. Okay. And was that in the old building or the new ER building?
A. It's all in our new department.
Q. So how far was it from the waiting room to the critical care bed where Cynthia went?
A. Oh, I've never paced it out. So I have to speculate.
Q. Well, just give me your best estimate. I mean, you've been there plenty of times, I'm sure.
A. Less than a minute wheeling the patient.
Q. How about in distance? Is it like 50 yards, 100 yards, or what?

A. Probably 30 yards.
Q. Okay. And so do you remember when you first saw Cynthia whether she was closer to the waiting room or closer to the -- what do you call it? The ICU room?
A. The critical care bed.
Q. Critical care bed, yeah.
A. Probably two-thirds of the way. I met her in the hall.
Q. And she's on a gurney?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. And being wheeled by -- who's wheeling her down the hallway?
A. I have no recollection of who was doing it.
Q. Okay. Is it nurses, techs, doctors? Do you have that recollection?
A. Well, it wouldn't have been doctors because I was the only one. So it would have been nurses and techs.
Q. And do you recall, like was it one person, five people? You have any recollection of that?
A. It would have been more than one because they had to get her in the bed and one person couldn't do that. But I don't have a recollection.

Q. Okay. So if she's on the floor in the waiting room, what would be the usual procedure if they're going to transport her to the critical care room? I mean, would it be on a gurney?
A. On a gurney.
Q. So someone would have taken the gurney from the ER down to the waiting room?
A. Yes.
Q. And then they lift her onto the gurney and then wheel her down to the critical care room?
A. Uh-huh.
Q. Yes?
A. Correct.
Q. And then when you get to the critical care room, would she be moved onto a bed or a table or something?
A. No. The gurney that was in there would have been pulled out, and the one that she was placed on originally would have gone back -- would have just gone straight into that slot.
Q. Okay. Let me see if I understand.
So she's wheeled down the hall. You follow her the last third of the way to the critical care bed in the ER. And then had someone already started CPR?
A. Yes.

Q. So as she's being wheeled, someone's doing what?
A. Somebody has a bag and they're bagging her and somebody's usually on the gurney doing CPR.
Q. Okay. And did you see that happening?
A. Oh, yes.
Q. All right. And then when she got to the room, did CPR continue on the gurney or was she moved to another thing?
A. The gurneys in the emergency department are essentially all identical. One went up to the lobby to get her. They bring her in, and they put it in the slot she's going into.
Q. I see. Okay.
A. If there was a gurney in that slot waiting, it would have been thrown out in the hall and she would have been moved in. So she was not transferred at another time.
Q. Okay. And at some point, the scribe, Kristina Arnold --
A. Uh-huh.
Q. -- joined you?
A. Correct.
Q. When did she join you?
A. Describes her pretty much with us the entire

here because anybody I can have come in off the street and they could speculate. But since you were there and you're familiar with this process, I want to make sure I'm getting your best estimate?

MR. FINKEL: Is that your best estimate as to opposed to speculation?

THE WITNESS: Yes. Yeah. This is the best -- this is the best estimate we can do.

BY MR. FLADSETH:

Q. Sure. That's all I want to get. Thank you. Okay. So 7:26 a.m. CPR began?

A. Correct.

Q. And I saw somewhere in the records that there was a reference to 7:20. Do you know what happened at 7:20?

A. I have no idea.

Q. Do you know what time Mrs. Gutierrez -- I'm not sure what the right term is -- crashed or collapsed to the floor or whatever happened in the waiting room?

A. I do not know.

Q. And do you know how long she'd been sitting in the waiting room before she crashed or collapsed?

A. I do not know.

Q. So as soon as she got into the critical care room, the -- all the staff, they're doing all these

things simultaneously, you're managing the airway, correct?

A. Correct.

Q. And so one of the monitors that she's being hooked up to immediately is the heart monitor?

A. Correct.

Q. And do you recall what that showed?

A. My note reflects that it showed a cardiac rhythm.

Q. What kind of monitor is that? I thought I heard you say "ultrasound" something at some point.

A. It's a monitor on the wall that has the wiggly lines.

Q. Like the little TV screen or computer screen?

A. Yes. Computer screen.

Q. Okay. And so is that -- what, is there like a prong that's put on the finger or something?

A. They're -- there are -- in this case, the patient would be on two monitors. They would be put on two. One is the defibrillator. If they're in cardiac arrest, they're hooked to a defibrillator immediately. That's two stickers that go (indicating) on the chest.

Q. So that's --

A. Anterior and posterior on the chest.

Q. Thank you.

A. The other monitor, and that would be -- that monitor would be on a bedside table. The other monitor has four stickers that are placed on the chest that reflect two different views of the EKG. An oxygen saturation monitor is hooked to that same monitor. That would tell us pulse rate and oxygen saturation. If functioning -- and it doesn't always function when there's not good blood flow.

The blood pressure cuff would be put on, and that also would be displayed on the monitor.

And through compliance, the respiratory rate would be displayed on that monitor. It's electronically calculated from the four leads.

Q. So where are these vital signs first documented?

A. The first set of vital signs are at 7:28. Heart rate of 38.

Q. And it looks like it says "intubated"?

A. That's the first thing that we do is establish an airway. So that first thing I do is, at the head of the bed, get that tube in. And that would have been the time that I did it.

Q. All right. So the first thing when she got into the critical care room is you would have intubated her?

A. Correct.

Q. And did you use a laryngoscope for that?

A. Correct.

Q. And so when you use the laryngoscope, what can you visualize?

A. I don't recall whether I used an electronic one or a manual one. I'm in the habit of using the manual because I have 30 years experience with that, and the electronic ones are the newfangled things.

But with either you can visualize usually the epiglottis and the arytenoids. Sometimes you can see the vocal cords.

Q. The epiglottic and -- what was the second one?

A. Arytenoids.

Q. How do you spell that?

A. I don't know.

Q. Say it one more --

A. Spelling was not a prerequisite for medical school.

Q. Yeah, I know. Okay. Just say it one more time.

A. Arytenoids.

Q. And what is an arytenoid?

A. The -- the epiglottis structure has the epiglottis, which is the valve that opens and closes and

which forms a circle. And the arytenoids are the little bumps around the outside edge that goes down to the posterior aspect of the opening.

Q. Okay. So what you're looking for is you want to make sure that you stick the bleeding tube into the lungs rather than the stomach, right?

A. Exactly.

Q. In lay terms anyway.

A. Stick it in the right hole.

Q. Okay. And when you use the laryngoscope, are you able to see the trachea?

A. Sometimes you can; sometimes you cannot.

Q. And --

A. And I don't have a recollection of whether I could at this point or not.

Q. Okay. Is there anything documented about when you use the laryngoscope whether you could see the trachea or not?

A. I don't think I put a -- in my medical decision making, I don't think I mentioned that.

No, I don't mention that, so I don't have a recollection.

Q. So the breathing tube is called an endotracheal tube?

A. Correct.

Q. Did you have any trouble getting it in immediately?

A. There's no indication that I had a problem.

Q. And there's ways that you verify that the endotracheal tube is in the lungs rather than the stomach, right?

A. Yes. The best way is visualize -- visualization. You watch it go in.

Q. Okay. And did you do any confirmatory tests?

A. We always do end-tidal CO2. And -- and on the critical care sheet, it should have said. It's not on that one.

So on the -- on page 182, page 6 of 8, intubation time, 7:35; reason, arrest; oral tracheal, 8 tube; crash intubation. And so confirmation equal chest rise, visualize going through the cords, condensation in the tube, and then post-X-ray confirmation with the position readjusted for correct depth.

Q. All right. So you put the tube in. You actually watched it go into the lugs so you --

A. Correct. Into the trachea.

Q. So you -- into the trachea. Thank you.

So you knew that the tube was going into the trachea so it would be oxygenating the lungs?

A. Correct.

Q. And then you did the end-tidal, T-I-D-A-L, CO2 measurement?

A. Correct.

Q. And did you do that immediately?

A. Yes. As soon as the tube is in, the respiratory therapist puts a little disc on there on the tube that there's a color change. So when there's no carbon dioxide, it's one color. When the patient expires, there is -- it changes color. It goes from blue to yellow.

Q. All right. So the -- you and the respiratory therapist were able to use the CO2 end-tidal test to make sure that the endotracheal tube was properly placed into the trachea and oxygenating the lungs?

A. That along with the other modalities we use.

Q. Right. But that's -- that was one of the things?

A. Correct.

Q. And then were you and the respiratory therapist also able to see the chest rising and falling which also confirmed the proper placement of the endotracheal tube?

A. Correct.

MR. FINKEL: Objection. Calls for speculation as to what the therapist could see.

BY MR. FLADSETH:

Q. Well, do you know whether the respiratory --

A. Well, I could certainly see it.

Q. Okay. Was that -- is that something that ordinarily the respiratory therapist is looking for, too, in the code blue, to your knowledge?

A. Yes.

Q. And then you mentioned there was some condensation in the tube?

A. Correct.

Q. Does that show whether the tube's been properly placed or not?

A. It is suggestive of that.

Q. And why is that?

A. We humidify air within when we breathe. So when you inhale, you inhale dry air, and when you exhale, you exhale wet air, essentially 100 percent humidity. And if it's cold, it's going to -- just like breathing on a window, it's going to fog up.

Q. And then chest X-ray was done also to confirm the placement of the endotracheal tube?

A. Correct.

Q. And when was that done?

A. Usually within -- within a minute or two after we get it in.

Q. So somebody has a portable chest X-ray at the bedside?

A. There's a machine that the respiratory therapists -- or that X-ray techs respond to all these codes, and they are in the hallway. And -- and when I as the captain of the ship say, "Time for X-ray," they come in and shoot the X-ray. And with the modern technology, there's a monitor on the X-ray machine and we can see it instantly.

Or I shouldn't say "instantly." Within ten seconds.

Q. So as soon as you get the endotracheal tube in, they do the chest X-ray within a few seconds?

A. Within a minute or two.

Q. Okay.

A. I should clarify that there's multiple things going on at the same time.

Q. Right. But one of the things you can see on the -- the chest X-ray is actually what projected on to one of the monitors?

A. Correct.

Q. And then you can confirm the proper placement of the ET tube?

A. Correct.

Q. And then when was the first oxygen level

documented?

A. It looks like at 7:34.

Q. What page are you looking at?

MR. FINKEL: Exhibit 2-2, the last page.

BY MR. FLADSETH:

Q. All right. So Exhibit 2-2, it has some times written across the top. The first one is 0734. And then you go down the list to the O2 sat. Looks like it's 100 all the way across for all the times there; is that right?

A. Correct.

Q. So as soon as you got the endotracheal tube in, was Cynthia immediately being oxygenated at 100 percent?

A. It appears that way, correct.

Q. Okay. What kind of O2 monitor was that? I mean, is it like one of those prongs you put on the finger or was someone actually, you know, sticking a needle in and drawing the blood?

A. No. It's a noninvasive monitor of some sort. Whether they had it on her ear or her nose or her finger, I don't know.

Q. But it ensured that the maximum amount of oxygen was getting in and she was being oxygenated with at 100 percent?

A. Correct.

Q. And that's from 0734 to, looks like, 0830, correct?

A. Correct.

Q. And how long were you in the critical room attending to Cynthia Gutierrez?

A. I don't recall, but probably at least for a half an hour.

Q. And were you ever having any trouble oxygenating her during that time?

A. No.

Q. During the time that you were in the critical care room with Cynthia, was any suctioning done for any reason?

A. Yes.

Q. When was it first done?

A. The -- once the endotracheal tube is placed, the respiratory therapist takes over that. I get the tube in. I hold my fingers on it to make sure it doesn't move. They take over and secure it, and then I move on to my next project. They take over.

The routine of the respiratory therapist is to suction immediately after they intubate a patient.

Q. Did you see whether the respiratory therapist suctioned in this case or not?

A. I did not see him do it. I know he did it but...

Q. How do you know he did it?

A. Because he told me.

Q. When did he tell you?

A. Shortly after when he suctioned, he pulled up a piece of food.

Q. So how long after you intubated Cynthia did the respiratory therapist pull up a piece of food?

A. I don't know.

Q. Was it seconds?

A. Minutes.

Q. Like how many minutes? Like two minutes? Ten minutes?

A. I don't have an answer to that.

Q. Okay. So let me see if I can just find any permeameter.

It wasn't more than an hour, was it?

A. Oh, certainly not.

Q. Okay. Was it closer to five minutes or 20 minutes?

A. More on the two- to five-minute time.

Q. Okay. Did you actually see a piece of food yourself?

A. Yes. He showed it to me.

A. I don't understand your question.
Q. Well, the reason you want to know what the cause is is so that would dictate what kind of treatment you provide, correct?
A. That would be on the backs of the critical care doctors.
Q. All right.
A. I stabilize the patient. That's my job.
Q. Okay. What did Dr. Kang say, if anything, when you told him that you thought the patient had aspirated some food?
A. I don't remember that he responded to that. He usually comes down, sees the patient, says, "I'll admit the patient," and leaves. And that's what I know.
Q. Do you know if Dr. Kang documented anything about food being in the airway or aspiration or anything like that?
A. I do not know.
Q. Did you have any discussion with Dr. Kang about whether Dilaudid may have played a role in the crash or not?
A. I have no recollection of having a discussion like that.
Q. So looking at the third page of Exhibit 2, which is 179 on the bottom right, so there's a little

box for the initial vital signs. Do you see that?
A. The bottom right on 179?
Q. No. The numbers at the bottom right, but now I'm up at the top.
A. Okay.
Q. The initial vital signs.
A. Okay. Yes.
Q. And who entered that information?
A. I have no idea. I assume one of the nurses. But I'd point out that this is after Dr. Kang has already seen the patient.
Q. How do you know that?
A. On page 182, progress note put in by the scribe: "Dr. Kang at bedside. He will admit patient. 7:45."
Q. So going down the page a little bit, it says "uremic frost."
What does that mean?
A. Which page are you on?
Q. 179, page 3 of Exhibit 2.
A. Uremic frost is a general appearance that renal failure patients have that gives them kind of whitish color.
Q. And had you observed that?
A. Yes.

Q. Page 180, this is the fourth page of Exhibit 2. Do you see that?
A. What am I looking at?
Q. Are you -- are you on the page?
A. Yes.
Q. Okay. You see where it says "X-ray, positive findings"?
A. Yes.
Q. It says "ET low."
What does that mean?
A. We alluded to that earlier; that on the X-ray, the endotracheal tube was repositioned. The radiologist then reads the X-ray after the fact, and that was one of his findings. I had already acted on that.
Q. So what time was the X-ray that's read as ET tube low?
A. You would have to go back and look at the X-ray -- the full X-ray report for a time stamp on it.
Q. So there should be a chest X-ray report at some time that shows the ET tube was low?
A. That's correct.
Q. And when did you first learn that the ET tube was low?
A. When I looked at the X-ray at the time it was taken.

Q. Okay. So is this the X-ray that's taken at the bedside immediately after you intubated?
A. Correct.
Q. So how low was it?
A. I don't recall.
Q. So you, what, pulled it back out a bit?
A. Yeah, I measured.
Q. So what was the measurement initially that you had used?
A. I don't recall.
Q. Was there somewhere that says something like 24 centimeters or something like that?
A. Yeah, it would have been 24 centimeters at the teeth is usually what they do.
Q. And then that ended up being too low?
A. Apparently.
Q. And what -- what was the new number?
A. I don't know.
Q. Did you document anywhere in your record that the tube had been placed too low and then moved?
A. I -- I did in -- oh, I saw it somewhere. "Position adjusted."
Q. Where are you looking?
A. We went through this before under the procedure note.

EXHIBIT E

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ALEXANDER M ARONOV, ESQ. (State Bar No. 316839); aaronov@dndmlawyers.com
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201 North Civic Drive, Suite 239
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Attorneys for Defendant
Elliot Brandwene, M.D. and Stewart Lauterbach, M.D.

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

CYNTHIA GUTIERREZ, JOSE HUERTA, SMH, RH and AH,

Plaintiffs,

vs.

SANTA ROSA MEMORIAL HOSPITAL, ST. JOSEPH HEALTH and DOES 1-50, inclusive,

Defendants.

Case No. 16-CV-02645-SI

DECLARATION OF DANIEL MCDERMOTT, M.D., IN SUPPORT OF DEFENDANT STEWART LAUTERBACH, M.D.'S MOTION FOR SUMMARY JUDGMENT

Date: June 8, 2018
Time: 9:00 AM
Dept.: Courtroom 1 – 17th Floor

Complaint Filed: May 17, 2016
Trial: November 19, 2018

ASSIGNED FOR ALL PURPOSES TO:
HON. SUSAN ILLSTON

I, Daniel McDermott, M.D. declare as follows:

1. I am a physician licensed to practice medicine in the State of California.

2. My education, training & experience consist of the following: I received my medical degree from the University of California, Los Angeles School of Medicine in 1993. I completed a residency in Emergency Medicine at Harbor UCLA Medical Center in 1996. From 1998 to November 2006, I was an Associate Clinical Professor with the Division of Emergency Medicine at the University of California, San Francisco. I have been a Per Diem Attending and Associate Clinical Professor in the Department of Emergency Medicine at the University of California, San

Francisco since 2006. I am an Attending Physician since 2006 as well as the Vice Chairman with the Emergency Department at California Pacific Medical Center. I am Board Certified in Emergency Medicine. A true and correct copy of my Curricular Vitae is attached hereto.

3. I was asked by the law firm of Donnelly, Nelson, Depolo, Murray & Efremsky to review documents related to the care and treatment rendered by Stewart Lauterbach, M.D. to plaintiff Cynthia Gutierrez and to render an opinion regarding whether that care and treatment was within the applicable standard of care.

4. Having been a full-time emergency physician in an acute care emergency department for over 20 years, I am familiar with the standard of care as it applies to an emergency room physician such as Stewart Lauterbach, M.D. I am familiar with the degree of skill, knowledge and care that other like emergency physicians would ordinarily possess, exercise and use in circumstances similar to those presented in this case. I feel qualified to opine regarding the care and treatment provided by Dr. Lauterbach to Cynthia Gutierrez under the circumstances of this case.

5. In connection with preparing this Declaration, I have reviewed the following materials in formulating my opinions: excerpts from the medical records of Santa Rosa Memorial Hospital and the deposition transcript of Dr. Lauterbach.

6. Based on my review of the above-referenced materials, I understand the pertinent facts to be as follows:

a. Plaintiff Cynthia Gutierrez presented at the Santa Rosa Memorial Hospital Emergency Department on February 25, 2015 at 03:26 a.m. with complaints of shortness of breath. She was evaluated and treated by Elliot Brandwene, M.D. and discharged at 7:00 a.m. Ms. Gutierrez waited in the Emergency Department waiting room for her ride home. (Records from Santa Rosa Memorial Hospital, 000219-000238.)

b. At 7:20 a.m., the Emergency Department Nursing Staff were informed that Ms. Gutierrez was unresponsive and had collapsed. (Records from Santa Rosa Memorial Hospital, 000243-000245, 000257-000263.)

c. The nursing staff immediately began CPR and placed a Bag-Valve-Mask (BVM) on Ms. Gutierrez to provide positive-pressure ventilation. Ms. Gutierrez was transported on a

stretcher to a critical care room in the Emergency Department while CPR and BVM continued to be performed. (Records from Santa Rosa Memorial Hospital, 000249.)

d. Dr. Lauterbach observed Ms. Gutierrez being transported to critical care room # 25 and arrived to provide care and assistance. (Deposition Transcript of Stewart Lauterbach, M.D., 21:7-18, 79:4-25, 80:1-12.)

e. Dr. Lauterbach gathered the necessary equipment in preparation for intubation of Ms. Gutierrez. Subsequently, he used a manual laryngoscope to visualize Ms. Gutierrez's epiglottis and her arytenoids. (Deposition Transcript of Stewart Lauterbach, M.D., 29:13-25, 30:1-2, 93:19-25, 94: 1-22.)

f. At 7:28 a.m., Dr. Lauterbach proceeded to insert an 8mm endotracheal tube (ETT) into Ms. Gutierrez's trachea. The ETT was positioned with Ms. Gutierrez's lips at the 24cm mark. Immediately thereafter, Dr. Lauterbach conducted the end-tidal CO2 measurement and confirmed the proper placement of the ETT. Additionally, Dr. Lauterbach confirmed the proper placement of the ETT by visualizing the vocal cords, observing the rising and falling of Ms. Gutierrez's chest, and noting condensation in the tube. (Records from Santa Rosa Memorial Hospital, 000243-000245; 000257-000262; Deposition Transcript of Stewart Lauterbach, M.D., 93:18-98:19.)

g. At 7:39 a.m., Dr. Lauterbach ordered an immediate portable x-ray of Ms. Gutierrez's chest. The x-ray showed moderate cardiomegaly with a biventricular contour. The ETT tube was confirmed to be in the trachea with the tip at the carina. The ETT was withdrawn by 2-3cm for more optimal placement. Ms. Gutierrez was oxygenated at 100% immediately upon placement of the ETT. (Records from Santa Rosa Memorial Hospital, 000274; Deposition Transcript of Stewart Lauterbach, M.D., 98:20-99:24, 100:1-25.)

h. Ms. Gutierrez was placed on a ventilator and connected to cardiac monitors. The cardiac monitor showed a narrow complex bradycardic rhythm. Dr. Lauterbach ordered calcium and bicarbonate based on the possibility of hyperkalemia. Subsequently, Dr. Lauterbach ordered epinephrine. (Records from Santa Rosa Memorial Hospital, 000257-000271.)

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i. At 7:45 a.m., Ms. Gutierrez was evaluated by Dr. Kang and admitted into in the Intensive Care Unit (ICU). (Records from Santa Rosa Memorial Hospital, 000257-000271.)

7. Based on my review of the aforementioned materials, my background and training, and expertise as an emergency medicine physician, I believe that Dr. Lauterbach met the standard of care in every respect.

8. It is my opinion that Dr. Lauterbach's decision to intubate Ms. Gutierrez on February 25, 2015 at 7:28 a.m. was entirely appropriate and within the standard of care. The Emergency Department staff was notified that Ms. Gutierrez had become unresponsive and collapsed in the waiting room. The nursing staff charted Ms. Gutierrez as being neurologically non-responsive, apneic, and having a pulse electrical activity (PEA) of 38. I believe that intubation was necessary at that time in order to preserve the patient's life.

9. It is my opinion that Dr. Lauterbach acted within the standard of care on February 25, 2015 at 7:28 a.m. when he intubated Ms. Gutierrez. First, Dr. Lauterbach gathered the necessary equipment to quickly begin the intubation. Second, he visualized Ms. Gutierrez's epiglottis and her arytenoid with a manual laryngoscope. Third, he placed an 8mm ETT into Ms. Gutierrez's trachea and positioned it at her lips at the 24 cm mark. Dr. Lauterbach then confirmed the proper placement of the ETT by conducting an end-tidal CO2 measurement, visualizing her vocal cords, observing the rising and falling of her chest, and noting condensation in the tube.

10. It is my opinion that Dr. Lauterbach acted within the standard of care on February 25, 2018 when he confirmed the placement of the ETT by portable x-ray. Immediately upon completing the intubation, Dr. Lauterbach ordered a bed side portable x-ray of Ms. Gutierrez's chest which showed the ETT to be in place at the tip of the Carina. It is further my opinion that Dr. Lauterbach then appropriately and within the standard of care adjusted the tip by 2-3cm to obtain optimal placement. Subsequently, Ms. Gutierrez was then connected to a ventilator by the respiratory therapist and admitted to the ICU.

11. I have carefully reviewed the provided medical records pertaining to Cynthia Gutierrez and it is my opinion that her intubation and resuscitation by Stewart Lauterbach, M.D. was within the standard of care and there is no evidence that Dr. Lauterbach was in any way negligent in his care

and treatment of Ms. Gutierrez.

12. It is further my opinion that no negligent acts or omissions on the part of Dr. Lauterbach caused or contributed to the harm, injury or damage allegedly suffered by Ms. Gutierrez.

I declare under penalty of perjury that the foregoing statements are true and correct.

Executed within the United States on 23 APRIL, 2018.

By: _____
DANIEL MCDERMOTT, M.D

Curriculum Vitae

Daniel A. McDermott, MD

Date of Preparation: 16 August, 2017
Place of Birth: Perth Amboy, New Jersey
Date of Birth: 2 October, 1966

Current Position: Attending Physician and Vice Chairman
Emergency Department
California Pacific Medical Center

Business Address: 2333 Buchanan Street, Level A
San Francisco, CA, 94115

Home Address: 183 Carl Street
San Francisco, CA 94117

Business Phone: 415-600-3333

Education:

July 1993-June 1996
Residency in Emergency Medicine
Harbor-UCLA Medical Center
Torrance, California

June 1989-June 1993
UCLA School of Medicine
Los Angeles, California
Doctor of Medicine

July1990-June 1991
University of Iowa
Iowa City, Iowa
American Heart Association, Research Fellow

June 1985-June 1989
University of California, Riverside
Riverside, California
Bachelor of Science, Biomedical Sciences

Licenses, Certifications

June 1998, Board Certified in Emergency Medicine

State of California, Board of Medicine-license G080226

Employment:

November 2006-present
Attending Physician, Emergency Department

Vice Chairman-December 2010-present
California Pacific Medical Center
San Francisco, California

November 2008-July 2012
Site Director
Pediatric Emergency Department
California Pacific Medical Center
San Francisco, California

November, 2006-Present
Per Diem Attending
Faculty Member, Associate Clinical Professor, Step 1
Department of Emergency Medicine
University of California, San Francisco

Previous Employment:

October 1998-November, 2006
Associate Clinical Professor
Division of Emergency Medicine
Department of Medicine
University of California, San Francisco

Honors and Awards:

March, 2017
Outstanding Author-Adult Emergency Medicine
The Approach to the Patient with Syncope in the Emergency Department

March, 2009
Achieving Continuous Excellence (ACE) Award, CPMC Medical Center

March 2005
Nominated for Outstanding Preceptor, Foundations in Patient Care course

July 2000
UCSF Division of Emergency Medicine Teaching Award
March 1992
Alpha Omega Alpha Research Prize for meritorious research in Biomedical Sciences

Professional Activities:

May, 2014
Sub-investigator
BI 655075 Re-Verse-AD study
California Pacific Medical Center

September, 2013
Member, Scientific Committee
First International Workshop on Syncope Risk Stratification in the Emergency Department
Lake Gargnano, Italy

July 2013-present
ED representative
Utilization Management Committee at CPMC

June, 2013-present
Consultant-Applied Practice Strategies-Boston, MA
On line medico-legal primer to reduce risk in the ED

March, 2013
Kaizen Participant
Sepsis protocol at CPMC

June, 2011-present
Quality of Care Committee, CPMC
Review for complicated cases in the ED

1999-2006
Member, Society for Academic Emergency Medicine

1999-2006
Member, American Academy of Emergency Medicine

2001-2005
California Academy of Medicine

Invited Papers, Lectures and Presentations

September, 2013
Survey Results presentation
First International Workshop on Syncope Risk Stratification in the Emergency Department
Lake Gargnano, Italy

July, 2013
The San Francisco Syncope Rule to Predict Patients with Serious Outcomes
Noon conference for the internal medicine residents
CPMC

Also presented at the following:

July, 2013
Morning Report for the Departments of Medicine and Cardiology
CPMC

April, 2013
Noon conference for the internal medicine residents
CPMC

November, 2012
Grand Rounds, Humanitas Medical Center
Milano, Italy

July, 2012
UCSF Emergency Department Resident Conference

November, 2011
Topics of Emergency Medicine
UCSF CME conference

August, 2010
UCSF Emergency Department Resident Conference

July, 2010
CPMC Resident Rounds

November, 2008
Topics in Emergency Medicine
UCSF CME Conference

July 2008
UCSF Emergency Medicine Residency Conference

September, 2007
Medicine Grand Rounds, California Pacific Medical Center

September 2006
Presented at Highland General Hospital Department of EM Grand Rounds

September, 2006
Grand Rounds
Presented to the faculty at The Community Hospital of the Monterey Peninsula

August, 2006
Grand Rounds
Presented to the faculty at San Francisco General Hospital

June, 2006
Grand Rounds
Presented to the EM residents at UCSF-Fresno

May, 2006
California Emergency Physicians, Annual CME Symposium, Riverside, California

April, 2006
Inter-American Conference on Emergency Medicine
Buenos Aires, Argentina

April, 2006
California Emergency Physicians, Annual CME Symposium, Sonoma, California

October, 2005
Topics of Emergency Medicine, a UCSF CME Conference

August 2005
Highland General Hospital, Emergency Medicine Grand Rounds

March 2005
For emergency physicians at Kaiser South San Francisco

October 2004
Topics in Emergency Medicine, a UCSF CME Conference

August 2004
For Highland General Hospital Emergency Medicine Conference

August 2004
For emergency physicians at Kaiser, San Francisco

May 2004
For emergency physicians at Kaiser, Vallejo

January, 2013
Expert Panel Discussant
Highly sensitive troponin: Have we ruled in how to rule out?
CPMC Cardiology ED Grand Rounds

November, 2010
"Fall Down, Go Boom"-Pediatric Head Injury
Pediatric Specialty CME Symposium
Sonoma, California

November, 2010
Pediatric Head Injury
Pediatric Residents at CPMC
Also presented December 2009 and May, 2010

May, 2009
Acute Stroke in the Emergency Department
State of the Art Stroke Symposium
CPMC CME Conference

October, 2007
Intersessions for 3rd year medical students at UCSF
Course IDS 112
Invited Panel Discussant
Ethical issues in different specialties on death and dying
Also Participated in October 2006

December, 2006
Guest Instructor and Proctor

Levitan Difficult Airway Course and Cadaver Lab
Given for San Francisco Paramedics Association
Also given April, 2006

November, 2006
Difficult Airway Workshop
Topics of Emergency Medicine, a UCSF CME Conference

Also presented October 2005

September 2006
IDS 101-Prologue Block
The Danovic Case
Presented to the 1st year Medical School Class at UCSF

August, 2006
Lecture, Cardiovascular Emergencies
Nursing Training Program
UCSF Emergency Department

Also presented February, 2006

March 2006
Oral presentation
Acute Myocardial Infarction and ECG Abnormalities in Emergency Department Patients Presenting with Syncope
SAEM Western Regional Research Conference, Redondo Beach, CA

February, 2006
Panel Member
Emergency Medicine Advisory Committee for UCSF Medical Students

December 2005
Guest participant
Heart Tone Detection Study
UCSF Division of Cardiology

October 2005
Invited guest panelist
Preceptor Workshop, for Foundations in Patient Care, IDS 131/132

September, 2005
Guest Speaker
EM Advisory Panel for the Emergency Medicine Interest Group

May, 2005
Moderated Poster presentation
Use of Hospital Admission for Emergency Department Patients with Syncope
SAEM Annual Conference, NY, NY

April, 2005
Moderated Poster presentation
Use of Hospital Admission for Emergency Department Patients with Syncope
SAEM Western Regional Conference

November, 2004
The Evaluation of Syncope
Lecture, The Emergency Medicine Interest Group, UCSF Medical Students

June, 2004, as well as May, September, 2003
Lecture, Medico-Legal Primer
UCSF Primary Care Residents Conference

April, 2004
Guest Participant, Career Planning Session
Emergency Medicine Interest Group for The UCSF Medical Students

November, 2003
Lecture, Follow-Up Conference
Joint Conference with UCSF Division of Emergency Medicine and Highland General Hospital Emergency Medicine

October, 2003, as well as October 2000-2002
Lecture, Local and Regional Anesthesia Workshop
Topics of Emergency Medicine

September, 2003
Lecture, Apparent Life Threatening Events
Joint Conference with UCSF Division of Emergency Medicine and the Department of Pediatrics

June, 2003
Guest Participant, Babinski research study, Department of Neurology,
UCSF Medical Center

May, 2003
Oral Poster Presentation, Syncope and EKG's
SAEM National Meetings, Boston, MA

April, 2003
Oral Presentation, Syncope and EKG's
SAEM Western Regional Conference, Scottsdale, AZ

April, 2003
Guest Participant, Career Planning Session
Emergency Medicine Interest Group, for UCSF Medical Students

June, 2002
Lecture, The Difficult Airway
UCSF Emergency Department Faculty Education Conference

December 2001, as well as September 2000, February 2001
Lecture, Nurse In-service on Abdominal Trauma

December 2001, as well as February 1999, 2001 and September 2000
Lecture, Nurse In-service on ENT Emergencies

October 1999
Lecture, Maxillo-facial Trauma
Topics of Emergency Medicine

Administrative Duties:

December, 2010-Present
Vice Chair, Emergency Department
CPMC

August, 2017
Neurosciences Search Committee-Chairman

April, 2017-Present
Neurosciences Quality of Care Committee

January, 2015-Present
ED Quality of Care Committee

November , 2010
CPMC Ophthalmology Reappointment Committee

June, 2010
CPMC Surgery Reappointment Committee

November, 2008-July 2012
Care of the Pediatric Patient
CPMC Campus

September, 2008-July, 2012
Site Director
Pediatric Emergency Department
CPMC, California Campus

July, 2007
Coordination of Difficult Airway Cart at CPMC

June, 2007-present
ED Physician Liason, Stroke Service at CPMC

March 2005-November 2006
Physician Representative, The San Francisco Emergency Physicians Association
Member of the Executive Committee

October, 2004-November 2006
Physician Representative, Hospital Committee on the Prevention of Delirium in Patients with Alcohol Withdrawal

June 1998-November 2006
Schedule Coordinator, UCSF Emergency Department

1998-2003
Physician Representative, Nurse Liason/Collaborative Practice Committee

1999-November 2006
Housestaff Coordinator/Schedule Coordinator for Rotation in the Emergency Department

July 2000-2004
ED Chart Compliance Coordinator

July 2002-November 2006
ED Staffing and Credentialling Coordinator

Teaching:

November, 2009
Instructor, Pediatric ED Nursing Skills
Adult EKG interpretation

September, 2009
Instructor, Pediatric Intern Procedure Course

May, 2006
Physician Preceptor, IDS 111:Longitudinal Clinical Experience

May, 2006
ACLS instructor for UCSF Medical Students

April, 2006
Instructor, UCSF Medical Student Course on Advanced Procedures Lab

April, 2005
Physician Preceptor, IDS 111: Longitudinal Clinical Experience

April, 2005
ACLS Instructor, for UCSF Medical Students

March, 2005
Instructor, UCSF Medical Student Course on Advanced Procedures Lab

June, 2004, as well as June 2003
ACLS instructor for the Incoming Surgical Interns

May, 2004
ACLS Instructor, for UCSF Medical Students

March, April, 2004
Instructor, UCSF Medical Student Course on Advanced Procedures Lab

April, 2000-2006
Oral Board Reviewer, Highland General Hospital Emergency Medicine Residents
6 Residents per 4 hour session, Bi-annually

June 2000-2007
Foundations in Patient Care-Course IDS-131/132
Physician Sponsor for 1st year UCSF Medical Students
6 hours per month during the Academic Year

June, 2000-June 2002
ACLS Course Coordinator for DOM incoming interns

June, 1999
ACLS Instructor for DOM incoming interns

Clinical Responsibilities:

My primary current role is attending in the Emergency Department at CPMC, where I am Vice Chairman. I work clinically approximately100 hours per month in this regard, usually 12-13 shifts. My responsibilities include direct patient care in the Emergency Department. I was previously the site director at the Pediatric ED as well at CPMC.

I also work 1-2 shifts as a supervising attending in the Emergency Department at UCSF, where I oversee interns and residents and coordinate the care of patients in the ED.

Clinical Research Program:

My research interests are in the evaluation of patients presenting to the Emergency Department with Syncope. In collaboration with my mentor, Dr. Jim Quinn, we have developed a prediction rule for short-term serious outcomes, The San Francisco Syncope Rule (SFSR). This has been the largest prospective syncope trial to date. We

have recently published the derivation of the rule and are currently submitting the validation phase for publication. We also plan to implement the rule at multiple centers as well. We have also looked into how well the SFSR has performed at predicting one-year mortality in the derivation cohort, and would like to evaluate for the validation cohort as well. I have received REAC funding for further investigation on this project. We are also interested in the classification of low risk patients with syncope, and would like to target this population to determine if they can be safely discharged from the Emergency Department.

In addition, I also am interested in syncope patients presenting with abnormal EKG's. I have looked at specific EKG abnormalities associated with serious outcomes as well as the association with acute myocardial infarction.

I am working with another colleague, John Stein, with the use of Ultrasound for peripheral IV access in patients that have difficult IV access. We currently have completed our randomized trial.

Research Support:

June, 2005
Mentor: Dr. Jim Quinn
Project: Evaluation of the San Francisco Syncope Rule to Predict Long Term Mortality
Source: REAC-UCSF School of Medicine
Amount: $9,980

May 2005
Mentor: Medical Scholl Research Program, Summer Research Fellowship
Project: Nursing trial for Ultrasound-Guide Peripheral Intravenous Cannulation
Source: Genentech Foundation/School of Medicine
Amount: $3,200

May, 2004
Mentor, Medical Student Research Program, Summer Research Fellowship
Project: Ultrasound-Guided Peripheral Intravenous Cannulation
Source: Genentech Foundation/School of Medicine
Amount: $3200

Peer Reviewed Publications:

McDermott, DA, Meller, ST, Gebhart, GF, Gutterman, DD. Use of an indwelling catheter for examining cardiovascular response to pericardial administration of bradykinin in rat. Cardiovascular Research 1995; 30:39-46.

Quinn, JV, Stiell, IG, McDermott, DA, Sellers, KA, Kohn, MA, Wells, GA. Derivation of the San Francisco Syncope Rule to predict patients with short term Outcomes, Annals of Emergency Medicine 2004; 43:224-232

Quinn, JV, Stiell IG, McDermott, DA, Kohn MA, Wells GA. The San Francisco Syncope Rule vs. Physician Judgment and Clinical Decision Making. Am J Emerg Med. 2005 Oct; 23(6): 782-6.

Quinn, JV, McDermott, DA, Stiell, IG, Kohn, MA, Wells, GA. Prospective Validation of the San Francisco Syncope Rule to Predict Patients with Serious Outcomes. Annals of Emergency Medicine 2006; 47(5): 448-454.

Quinn, JV, McDermott, DA, Kramer, N, et al. Death After Emergency Department Visits for Syncope: How Common and Can It Be Predicted. Annals of Emergency Medicine 2008: 51(5): 585-90.

Quinn, JV, Kramer, N, McDermott, DA. Validation of the Social Security Death Index (SSDI): An Important Readily-Available Outcomes Database for Researchers. West JEM 2008 9(1) article 2.

McDermott, D, Quinn, J, Murphy, C. Acute Myocardial Infarction in Patients with Syncope. CJEM 2009; 11(2):156-60.

Stein, JC, George, B, River, G, Hebig, A, McDermott, DA. Ultrasonographically Guided Peripheral Intravenous Cannulation in Emergency Department Patients With Difficult Intravenous Access: A Randomized Trial. Ann Emerg Med. 2009; 54: 33-40.

Quinn JV, McDermott D, Rossi J, Stein J, Kramer N. Randomized controlled trial of prophylactic antibiotics for dog bites with refined cost model. West J Emerg Med. 2010 Dec;11(5):435-41

Quinn, JV, McDermott, DA. ECG Findings in Emergency Department Patients with Syncope. Acad Emerg Med. 2011 Jul;18(7):714-8.

Costantino G, Solbiati M, Casazza G, Bonzi M, Vago T, Montano N, McDermott D, Quinn J, Furlan R. Usefulness of N-terminal pro-B-type natriuretic Peptide increase as a marker for cardiac arrhythmia in patients with syncope. *Am J Cardiol* 2014;**113**(1):98-102.

Costantino G, Casazza G, Reed M, Bossi I, Sun B, Del Rosso A, Ungar A, Grossman S, D'Ascenzo F, Quinn J, McDermott D, Sheldon R, Furlan R. Syncope risk stratification tools vs. clinical judgment: an individual patient data meta-analysis. Am J Med. 2014 Nov;127(11):1126.e13-25.

Sun BC, Costantino G, Barbic F, Bossi I, Casazza G, Dipaola F, McDermott D, Quinn J, Reed M, Sheldon RS, Solbiati M, Thiruganasambandamoorthy V, Krahn AD, Beach D, Bodemer N, Brignole M, Casagranda I, Duca P, Falavigna G, Ippoliti R, Montano N, Olshansky B, Raj SR, Ruwald MH, Shen WK, Stiell I, Ungar A, van Dijk JG, van DN, Wieling W, Furlan R. Priorities for Emergency Department Syncope Research. *Ann Emerg Med* 2014. Volume 64, Issue 6, December 2014, Pages 649–655.e2

Costantino G, Sun BC, Barbic F, Bossi I, Casazza G, Dipaola F, **McDermott** D, Quinn J, Reed MJ, Sheldon RS, Solbiati M, Thiruganasambandamoorthy V, Beach D, Bodemer N, Brignole M, Casagranda I, Del Rosso A, Duca P, Falavigna G, Grossman SA, Ippoliti R, Krahn AD, Montano N, Morillo CA, Olshansky B, Raj SR, Ruwald MH, Sarasin FP, Shen WK, Stiell I, Ungar A, Gert van Dijk J, van Dijk N, Wieling W, Furlan R. **Syncope** clinical management in the emergency department: a consensus from the first international workshop on **syncope** risk stratification in the emergency department.
Eur Heart J. 2016 May 14;37(19):1493-8.

Sorenson, SB, Baranzangi, N, Chen, C, Wong, C, Grosevenor, D, Rose, J, Bedenk, A, Morrow, M, McDermott, D, Hove, JD, Tong, DC. Generalized Safety and Efficacy of Simplified Thrombolysis Treatment (SMART) Criteria in Acute Ischemic Stroke: The

MULTI SMART Study. J Stroke Cerebrovasc Dis. 2016-accepted for publication.

Non-Peer Reviewed Publications:

McDermott,D., Henneman,P. Penetrating Abdominal Trauma, Emergindex, Micromedex, Inc., 1995.

Koenig, KL. Emergency Medicine: Pre-Test Self Assessment and Review, Contributor, Pulmonary Emergencies chapter, McGraw Hill, 2000.

Quinn, JV, McDermott, DA. Editorial Correspondence-Risk Prediction Patients with Syncope. Annals or Emergency Medicine 2004; 44(4): 422-424.

Quinn, J, McDermott, D. Editorial Correspondence-Syncope and NAMCS.
Acad Emerg Med. 2005 Apr;12(4):381.

Quinn, JV, McDermott, D. Editorial Correspondence: Medical decision-making and the San Francisco Syncope Rule. Ann Emerg Med. 2006 Dec; 48(6): 762-3.

Quinn, J, McDermott, D. Editorial Correspondence-External validation of the San Francisco Syncope Rule. Ann Emerg Med. 2007 Dec; 50(6): 742-3.

McDermott, DA, Quinn, JV. The Approach to the Patient with Syncope in the Emergency Department, Up To Date, January 2007.

McDermott, DA, Quinn, JV. Editorial Correspondence-Response to "Failure to Validate the San Francisco Syncope Rule in an Independent Emergency Department Population." Ann Emerg Med. 2009 May 53(5): 693.

Quinn J, McDermott D. ECG criteria of the San Francisco Syncope Rule. Ann Emerg Med. 2011 Jan;57(1):72-3

Abstracts:

Quinn, JV, McDermott, DA, Kohn, MA, McCulloch, CE, Stiell, IG, Wells, GA. Physician agreement in the evaluation of patients presenting with syncope. Acad Emerg Med 2001; 8:558.
Abstract, accepted for poster presentation at SAEM, May, 2001.

Quinn, JV, McDermott, DA, Stiell, IG, Kohn, MA, Sellers, KA, Wells, GA. Physician judgment in evaluating patients with syncope. Acad Emerg Med 2002; 9:452-3.
Abstract, accepted for poster presentation at SAEM, May 2002

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Abstract, accepted for plenary session at SAEM, May, 2002.

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EXHIBIT F

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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIIA

CYNTHIA GUTIERREZ, JOSE HUERTA, SMH, RH and AH,

Plaintiffs,

vs.

SANTA ROSA MEMORIAL HOSPITAL, ST. JOSEPH HEALTH and DOES 1-50, inclusive,

Defendants.

Case No. 16-CV-02645-SI

DECLARATION OF ALEXANDER M. ARONOV IN SUPPORT OF STEWART LAUTERBACH, M.D.'S MOTION FOR SUMMARY JUDGMENT

Date: June 8, 2018
Time: 9:00 AM
Dept.: Courtroom 1 – 17th Floor

Complaint Filed: May 17, 2016
Trial: November 19, 2018

ASSIGNED FOR ALL PURPOSES TO:
HON. SUSAN ILLSTON

I, Alexander M. Aronov, Esq., declare:

1. I am an attorney at law duly licensed in the State of California and admitted to practice before this Court. I am an attorney with the law firm Donnelly Nelson Depolo Murray & Efremsky, attorneys of record for Defendant Stewart Lauterbach, M.D. I have personal knowledge of the matters stated herein, and if called as a witness, I could and would testify competently thereto. I have participated in the litigation of this case and have reviewed the file.

2. I certify that the document attached hereto as Exhibit A is a true and correct copy of ECF Doc No. 1-Plaintiffs' Complaint filed in this litigation as downloaded and printed out by this office during the course of this litigation.

3. I certify that the document attached hereto as Exhibit B is a true and correct copy ECF Doc No. 56 - Plaintiffs' Second Amended Complaint filed in this litigation as downloaded and printed out by this office during the course of this litigation.

4. I certify that the documents attached hereto as Exhibit C are true and correct copies of excerpts from medical records pertaining to plaintiff in this action as subpoenaed by this office from Santa Rosa Memorial Hospital during the course of this litigation.

5. I certify that the documents attached hereto as Exhibit D are true and correct copies of excerpts from the deposition transcript of Stewart Lauterbach, M.D.

6. I certify that the document attached hereto as Exhibit E is a true and correct copy of the declaration of Daniel McDermott, M.D.

Dated: 4/25/2018

By: Alex Aronov
ALEXANDER M. ARONOV

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